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PRESCRIPTION DRUGS AND MEDICARE FINANCING

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PRESCRIPTION DRUGS AND MEDICARE FINANCING

THURSDAY, MARCH 22, 2001

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

The hearing was convened, pursuant to notice, at 2:33 p.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Gramm, Jeffords, Snowe, Baucus, Rockefeller, Breaux, Conrad, Graham, and Lincoln.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. I thank everybody for being here on time. I am going to go ahead and start the meeting. Senator Baucus will be along very, very shortly. He is momentarily detained, and he said it is all right for me to proceed. So, I think I will do that.

We are dealing with the first or second most important issue that this committee is going to deal with this year. That is, however you want to arrange them, tax issues and prescription drugs/Medicare.

Staff has been working on all of these items for a long period of time. We do not want to wait until we get one done until we start the other, so we are having this hearing on Medicare financing and prescription drugs, tackling one of the toughest issues this year.

If you read the media headlines on the trustees' report this week, they all note the slight improvements in Medicare Part A's solvency. But this is only the short-term view. Taken in isolation, it is a very deceptive view.

Over the long term, the program is in a much greater deficit than previously projected. Taking a closer look at Medicare costs, the trustees now project that, over 75 years, Medicare costs will grow 1 percent faster than GDP.

In fact, the trustees project that promised Medicare benefits will exceed scheduled Medicare payroll taxes and premiums by $333 trillion over the next 75 years. An astounding number, $333 trillion. That does not even take into account the new prescription drug benefit.

Today, there are four workers for every Medicare beneficiary, but by 2030 there will be two and three/tenths workers per beneficiary. Add to that the retirement of the baby boom population, which will result in a doubling of beneficiaries by the year 2030.

Overall, as more beneficiaries enroll in Medicare over the next several decades, there are fewer workers paying taxes to cover ben-

efits, resulting in increasing costs to Medicare at the same time revenues are decreasing.

To bring Medicare into balance, the trustees project, in their report, over the next 75 years, either benefits have to be reduced by 37 percent, or revenues have to be increased by 60 percent.

Now, taken as a whole, Medicare is troubled even in the near term. If we compare all the money that the Federal Government collects to pay for Medicare to all the money the Federal Government spends on Medicare, we are short roughly $1 trillion over the next decade, which will obviously have to come from general revenues.

Our health care system today is much different than 35 years ago when Medicare was first enacted. For example, in the year 2000, Part A expenditures, mostly hospital services, grew a modest 2 percent, while Part B expenditures, physicians' visits, outpatient care, grew a whopping 10.2 percent. Furthermore, while 22 percent of the Medicare beneficiaries made use of Part A services, 87 percent of the beneficiaries took advantage of Part B services.

So we have to be very candid with our Nation's beneficiaries, and also to the taxpayers whose funds we are entrusted with, when we talk about Medicare's financial condition.

It is misleading to only account for hospital spending, which is Part A, when beneficiaries today rely on physician visits and outpatient care, which is Part B, to meet their health care needs.

Now, it is simple for me, as you just divide Part A and Part B. That is inside the Washington beltway talk. When I am visiting with my constituents in my town meetings in Iowa and they come up and talk to me about, leave my Medicare alone, or they can say, I am concerned about Medicare, or this, or that.

I have never had one of them tell me, I am worried about Part A, but not Part B, or vice versa. Medicare is Medicare to my constituents, and my people are as well-educated as any citizenry of any of the 50 States.

After hearing today's testimony, I hope we can all agree that, in light of the enormity of the potential cost of prescription drug coverage and Medicare's worsening financial condition, we must be fiscally responsible for adding any new benefits to Medicare.

Equally important, we must consider carefully the larger picture. While prescription drugs may be one of the most visible improvements in Medicare, it is clearly not the only modernization that we can do for Medicare.

We have an opportunity to strengthen and improve Medicare overall. We owe it to our beneficiaries who rely on Medicare to make sure that there is a 21st century program in place commensurate with the practice of medicine, not last century's practice of medicine, so that our providers who strive to deliver high-quality care, and the taxpayers who foot the increasing costs of the program, could both be satisfied.

It is clear that we have a major challenge ahead of us. I am committed to working with all of the people on this committee to find a viable solution.

Unless you folks have come prepared to give an opening comment, I am going to go immediately to the witnesses. For sure, I

am going to let Senator Baucus say something when he comes. But go ahead.

OPENING STATEMENT OF HON. JAMES M. JEFFORDS, A U.S. SENATOR FROM VERMONT

Senator JEFFORDS. Mr. Chairman, we also know that we all are enjoying living longer because of Medicare. The problem is, everybody else is living longer. As we look to the future and see the longevity increases that are going to be with us in the middle of this next century, we know that what we do now is going to be very important as to where we end up then. Thank you.

The CHAIRMAN. Thank you very much.

We now have Dan Crippen, director of CBO, who will discuss CBO's new projections on drug spending by Medicare beneficiaries and the underlying causes for these sharp increases.

Then following Dr. Crippen we will have General Walker, of the General Accounting Office. Mr. Walker will explain the general revenue sources on which Medicare programs depend, the treatment of those funds under current law, and anticipated trends in Medicare revenues, costs, and demographics that may impact short-and long-term growth.

Dr. Crippen?

STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. CRIPPEN. Thank you, Mr. Chairman, and other members of the Committee. I am certainly pleased to be here today. In fact, as I was thinking about it, I am pleased to be here at all to describe Medicare's financial outlook on issues affecting the design of the Medicare prescription drug benefit.

The annual report, as you have said, Mr. Chairman, released earlier this week by the Medicare Board of Trustees, indicates that the Hospital Insurance (HI) trust fund's expenses will exceed its dedicated noninterest revenues beginning in 2016. We believe at CBO that it will actually be sooner than that.

Nonetheless, by 2029, the year of projected trust fund exhaustion, dedicated revenues to the HI trust fund will equal only 68 percent of the program's costs. By 2075, HI revenues would cover only 32 percent of HI spending.

The trustees' report projects that total Medicare spending, including Parts A and B, will increase from 2.2 percent of gross domestic product (GDP) in 2000 to 8.5 percent in 2075, at which point almost three-quarters of the spending will have to be funded by general revenues.

After several decades of relatively slow growth in the number of beneficiaries, the retirement of the baby boomers between 2010 and 2030 will almost double Medicare's enrollment. According to the trustees, there will be 77 million beneficiaries in 2030. While beneficiaries will increase by 95 percent between now and then, the number of workers will increase by only 15 percent.

In addition to doubling the number of beneficiaries, the cost per beneficiary will continue to grow faster than the economy. As a result, Medicare will consume an ever-increasing share of GDP.

It is important to keep in mind, Mr. Chairman, that Medicare is only one of the Federal programs that transfers resources from the working population to the retired and disabled. This poster, which you have all seen before, illustrates what the near future might look like if we take no action. Just these three Federal programs will grow from 7 percent of GDP to 15 percent of GDP by 2030.

These demographic factors and financial pressures have focused policymakers' attention on restructuring the Medicare program. There are two basic and potentially conflicting issues, both of which I think you have already noted, Mr. Chairman.

First, Medicare spending is expected to grow at a rapid rate, making the program increasingly dependent on general revenues and, ultimately, unsustainable.

Second, Medicare does not provide the protection offered by most private insurance, since it lacks a stop-loss amount and prescription drug coverage.

The rest of my remarks this afternoon are directed to spending by Medicare beneficiaries on prescription drugs today, and some of the implications for a Medicare drug benefit in the future.

In recent years, growth in prescription drug spending has far outpaced growth and spending for other types of health care, as you can see from the next chart (see page 119). Even without a Medicare drug benefit, CBO expects prescription drug costs for the elderly to grow at an average annual rate of 10.3 percent per person, twice the pace of combined costs for Medicare Parts A and B and much faster than growth of the nation's economy, ultimately costing $1.5 trillion over the next 10 years. That is a figure I will come back to in a moment, Mr. Chairman.

In 1997, about one-third of the Medicare population had no prescription drug coverage, but nearly 70 percent did. Even among those who had coverage, the generosity of those drug benefits varied a lot.

Given the recent trends in drug spending, even more generous sources of coverage are taking measures to reign in cost growth, which adds to the pressure for a new drug benefit via Medicare.

Proposed Medicare drug benefits address a number of objectives, but they are often mutually incompatible, so that ultimately, difficult choices will have to be made to have a workable program.

For example, with a voluntary program, in which most of the costs would be paid by enrollees' premiums to keep the impact on current workers small, some Medicare beneficiaries would be unwilling or unable to participate. Similarly, a drug plan covering only catastrophic expenses, although providing insurance to everyone, would directly benefit relatively few enrollees in any given year, probably reducing support for the program.

Limiting costs by capping the annual benefits paid to enrollees, which we have seen in most recent proposals, would fail to protect participants from the impact of catastrophic expenses.

As the third chart shows, although most Medicare enrollees use some prescription drugs, the bulk of such spending is concentrated in a much smaller group. In 2004, about 13 percent of enrollees will have expenditures of $5,000 or more, accounting for 46 percent of total spending by the Medicare population. Forty-one percent

will have expenditures of $1,000 or less, making up about 5 percent of total spending for pharmaceuticals.

Most of the higher costs and long-term spending is associated with treatment of chronic conditions such as hypertension, heart disease, and diabetes.

The skewed distribution of spending and the need for people with chronic conditions to stay on drug therapies over the long term make stand-alone drug coverage particularly susceptible to adverse selection, in which enrollment is concentrated among those who expect to receive more in benefits than they would pay in premiums.

The last chart is a pie chart that shows the current sources of financing for today's drug use by the elderly. As you will see, about 45 percent is out-of-pocket spending; the rest is covered by various types of insurance. By the way, the out-of-pocket ratio here is very similar to that of private insurance: Nonelderly people who have insurance pay about 39 percent out of pocket.

If a Medicare drug benefit was designed to look like the benefit typically provided by employer-sponsored plans, it would have to be integrated with the rest of the Medicare benefit and would be very costly. Not only would it transfer some of the costs of drugs currently used by beneficiaries to Medicare but it would also increase utilization among those with less generous coverage now.

Let me conclude by highlighting the amount spent on outpatient prescription drugs by the elderly today, which makes it obvious that it will be costly to provide a generous drug benefit to all Medicare beneficiaries. Either enrollees' premiums or taxpayers' costs would have to be high.

Again, over the period from 2002 to 2011, we estimate that about $1.5 trillion will be spent on prescription drugs for the elderly. Thus, a rough cut of a drug benefit that covers, say, 50 percent of enrollees' spending would suggest a cost of at least $728 billion over the next 10 years. Again, very roughly, if the current Medicare Part B subsidy applied, the 10-year cost would be $900 billion.

If, on the other hand, all costs above $1,000 a year were covered, costs through 2011 would be $1.1 trillion. If only costs above $5,000 a year were covered, costs for the next 10 years would be $365 billion.

Obviously, those are all very large numbers. But the amount of spending on drugs by the elderly today is even greater.

Mr. Chairman, just as you and I are currently paying for Medicare benefits for our parents and grandparents, our children and grandchildren will pay for us after we retire. Adding a drug benefit would significantly increase Medicare's costs. Unless it was largely financed by enrollees' premiums, the burden on our children would be even greater.

I look forward to answering your questions, Mr. Chairman.

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

The CHAIRMAN. Thank you, Dr. Crippen.

Now, General Walker?

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

Mr. WALKER. Thank you, Mr. Chairman and members of the committee. Let me apologize in advance for my voice. I am trying to recapture it.

I am pleased to appear today to consider the need to strengthen and modernize the Medicare program. Although Medicare's short-term outlook as improved since I last testified, the long-term outlook is much worse. The Medicare trustees and the Congressional Budget Office now agree that spending will grow faster than previously predicted.

At the same time, the fiscal discipline imposed by the Balanced Budget Act of 1997, BBA, continues to be challenged, while interest in modernizing the Medicare benefits package, to include prescription drug coverage, has increased.

As a result, the need for meaningful Medicare reform is clearer today than it was a year ago. With regard to that, it is important to note that any benefit expansion efforts should be coupled with adequate program reforms so as not to worsen Medicare's long-term financial condition.

Ultimately, any comprehensive Medicare reform proposal must include several elements and address several fundamental challenges. But before I do that, let me show you a quick summary of the changes between last year's trustees' report and this year's.

What you will see is good news and bad news. On the good news front, from a solvency standpoint, the HI trust fund has gone from 2010 to 2016 on solvency. The trust fund is projected not to become exhausted until 2029, versus 2025.

As I will say in a few minutes, Mr. Chairman, frankly, I think solvency is the wrong measure. We need to be focusing on sustainability. Solvency is largely a legal issue, it is not an economic issue. Economics is what we need to be focused on, in my opinion.

On the other hand, if you look at the long-range actuarial balance for the program, it has significantly worsened in the last year. As you can see by the actuarial balance, the difference in the cost in year 75, as well as the percentage of the economy that the combined Medicare program these figures have gotten worse. I agree, Mr. Chairman, we should not talk about Part A and Part B, we need to speak about the combined program. What is the combined burden going to be as a percentage of the overall economy and as a percentage of the budget?

Importantly, one number that was not disclosed in the Trustees' report, but we now have available, is that the estimated net present value of the unfunded liability for the HI program alone increased in the last year from $2.6 trillion to $4.6 trillion and this number does not count the SMI program.

The press accounts have been focusing on solvency. It is not that solvency is not important. It is important that we have assets or promises to back commitments. Benefits cannot be paid without sufficient revenues or Treasury numbers in the trust fund.

But the real key issue is sustainability. What percentage of the budget, what percent of the economy do these programs represent, and recognizing they are competing with other priorities in the Federal Government in that regard.

In summary, over the long term, our budget simulations show that demographics and health care spending will drive us into long-range deficits and debt. Our January 2001 long-term simulation shows that, even if the entire unified surplus was saved—and that is not going to happen—then we will ultimately be driven back into deficits and debt.

But the more likely scenario is—and I am not endorsing this scenario, but let me articulate it for illustrative purposes only. If Congress saves every penny of the Social Security surplus through paying down debt, but if Congress ends up spending the on-budget surplus either through tax cuts, or spending increases, or a combination thereof, this is our likely future in 2030 and 2050. The line represents revenues as a percentage of GDP. Right now, they are 20.6 percent of GDP.

We assume, under the scenario that I gave you, half and half—I am not saying we endorse that—half to spending, half to tax cuts, obviously, with an increase in interest on the debt that relates thereto. If you assume that, you can see what would happen to the line.

If you look at what happens to the growth and spending based upon CBO projections and based upon the Social Security and Medicare trustee projections, basically, you will see that, by 2030, we have to haircut discretionary spending by about 50 percent. By the year 2050, we do not have any money for discretionary spending, nor for Medicare or Medicaid. The issue is sustainability, not solvency.

Medicare spending is likely to grow faster than previously estimated. As I mentioned, the unfunded liability has gone from $2.6 trillion last year to $4.6 trillion, an increase of about 75 percent in 1 year alone.

The measure of Medicare's condition can no longer be merely the traditional focus of HI trust fund solvency that has been used in the past. Both Part A and Part B expenditures need to be considered, and we need to look at the overall burden.

Since the cost of a drug benefit will boost the spending projections even further, adding drug coverage under Medicare's already dark financial cloud will require difficult policy choices that will likely have a significant effect on beneficiaries, the program, and the marketplace.

Properly structured reforms to promote competition among health plans can help to make beneficiaries more cost-conscious. However, improvements to traditional fee-for-service Medicare is also critical, because no matter what you do, a vast majority of beneficiaries are likely to remain in fee-for-service for some period of years.

Therefore, it is important that that program be reformed and made more efficient and cost effective. Fiscal discipline is difficult, but it is essential given the projections that I have shown you.

Reform of Medicare's management is also important in order to help make progress in the traditional fee-for-service plan. Ultimately, we will need to look at broader health care reforms incrementally, over time, in order to balance health care spending with other societal priorities. In doing this, it is going to be important

that we look at all Federal policy tools: tax preferences, spending, as well as regulation.

It is also important that we start focusing on the fundamental differences between wants, which in health care are unlimited, needs, which can and should be defined, and to the extent possible met, and overall affordability, of which there is a limit, especially in the health care area.

In summary, Mr. Chairman, the short-term situation looks better. The long-term situation is much worse. Solvency is not the issue. Sustainability is the issue. Both are important, but sustainability is the real ball game.

The projections I showed you do not consider any prescription drug benefit. Therefore, it is going to be incredibly important that you consider the long-range challenges before you consider benefit increases. I would respectfully suggest that the Congress may want to consider adopting a Medicare reform Hippocratic oath. That is, do not make the long-term situation worse.

Thank you, Mr. Chairman.

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

The CHAIRMAN. Thank you, General Walker.

I am going to turn to Senator Baucus for his opening statement for the Democrat side. Then we will take 5-minute rounds of questions in this order: Grassley, Baucus, Gramm, Jeffords, Breaux, Conrad, Snowe, Lincoln.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

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

I would like to talk a little bit about prescription drug benefits. This hearing is about both Medicare reform and about prescription drug benefits. We have heard a lot of about reform.

Reform is in the eyes of the beholder. It means different things to different people. But I would like to say a few words about prescription drugs because, as after all, that is half of this hearing.

I apologize. I was not here earlier, so I do not know whether either Dr. Crippen or Mr. Walker talked about the increase of the estimates for drug spending. It is my understanding that the increase in spending for the next decade, for prescription drugs, is going to be about 30 percent higher than earlier. That is 30 percent over what was estimated last year.

HCFA has also done some reestimating. They predict that drug costs will grow by about 13 percent a year through about 2010.

In my mind, that increase points out and makes the case for the enactment a prescription drug benefit. That is, if it is getting worse, that does not mean we should avoid it, that means we should tackle it. Remembering that, although Medicare beneficiaries comprise about 13 percent of the U.S. population, they account for one-third of all drug spending.

Two-thirds of Medicare beneficiaries have some sort of drug coverage. I think that we should do our utmost not to replace private dollars with public dollars. This is not going to be an easy solution.

Remember, Medicare beneficiaries without coverage pay higher drug prices than anyone else in the world. Just remember that.

Medicare beneficiaries in America, without coverage, pay higher drug prices than anyone else in the world.

These beneficiaries benefit from neither insurance, nor discounted prices. They are beneficiaries in name only for an increasingly important component of health care.

So when some of us talk about providing a prescription drug benefit, they say we need comprehensive reform. I understand that. I am more than willing to go down that road and try to figure out some comprehensive reform. Many members of this committee have ideas for prescription drug benefits. Senators Breaux, Rockefeller, Gramm, Snowe, Jeffords. There are many. I think they are proposals we should consider.

We should also take a look at work and efforts to make Medicare more efficient and responsive, both to patients and providers, and take a long, hard look not only at solvency, but as Mr. Walker suggested, at sustainability, and inject more market competition into the system.

But I want to be clear. Let us be careful about reforms. Deregulation, competition, is not a total panacea. It does not always work all the time, in all ways, in all places. Look at airline deregulation. Look at California's deregulation of its power market. My State of Montana has partially deregulated.

It has created havoc in a lot of these States. So, let us be careful about what we are doing. I am all for doing it, but let us think down the road a little bit before we go too far, too quickly.

So any changes we make for Medicare for reform or for prescription drugs, I think also has to make sense for rural America. Mr. Walker alluded to it, namely, the need for fee-for-service, because a lot of people are going to continue to pay fee-for-service. That is particularly true in rural America.

This is not a new issue. The House and Senate have debated and voted on prescription drug bills before. Many members of this committee have introduced prescription drug legislation.

In 1993, President Clinton's Health Security Act included a Medicare drug benefit. In 1988, President Reagan—we all know this—signed the catastrophic legislation, which included a drug benefit. That is, until the entire law was appealed in 1989.

In 1972, this very committee approved the first outpatient drug benefit to pass the Senate. 1972, this committee approved the first outpatient drug benefit. It passed the Senate, went to conference, and was stripped by the House.

The more things change, the more they stay the same. The price of the status quo has certainly never been higher than it is now. Drugs are ever important. They are more important, increasingly more expensive, a large part of health care.

We have a 10-year, $5.6 trillion surplus, not a $200 billion-plus deficit that existed during the last two attempts by this committee when we were going to go on to try and pass a prescription drug benefit.

So, clearly, it seems to me, if we have a budget surplus projected, that we ought to find out some way to solve this. It is not easy. Nobody is saying it is easy. But I do think we should have a universal prescription drug provision while we are trying to work out these reform measures.

I might say that I spent a little bit of time looking at all of the reforms by the administration, combining Part A and B, and so forth. Sure, there is kind of an insolvency problem on down the road, definitely. There definitely is one. Nobody has come up with a way to see how we are going to find the money. Nobody has come up with that.

We talk about reform, competition. Nobody has said how much money that is going to save. Nobody has. I have heard no estimates that amount to anything. It is all theory. So, let us just be careful.

The CHAIRMAN. Let us look at the history of that catastrophic health plan that he just talked about. When we passed that, that was estimated to cost $5.7 billion, and 1 year later the estimate was $11.8 billion. Now, that is a doubling of costs, just a handful of billions of dollars. Today, if we had a doubling of costs, it would be hundreds of billions of dollars.

Now, I know that your agency has come a long ways in estimating over that past decade. But, even so, is there not still a high degree of uncertainty in estimating drug costs into the future? And in your view, what are the implications of these uncertainties as we develop a plan for drug coverage this year?

Dr. CRIPPEN. Certainly, Mr. Chairman, there are lots of things that we do not fully know, particularly about the behavior of the elderly after you gave them a benefit like this. This is a major change in the way pharmaceuticals would be financed.

We believe that if you give insurance to folks, elderly or not, it will increase their utilization of drugs, and if you reduce the price to the rest of the population who are now using drugs, that, too, would probably increase utilization.

There are offsetting factors, though, and the size of those factors is uncertain. For example, as I said, we believe that utilization will go up if you introduce a broad-based universal drug benefit, but we are not exactly sure how much. We do not know for sure how quickly costs would grow after you introduced the benefit, which in some ways is a more important question.

The initial size of the benefit is somewhat easier to calculate—that is, how many people do you have, what is the average benefit you are going to give them. Those things are a little more certain. But what is uncertain is how fast that benefit is going to grow. Clearly, it would be a large benefit the first year. But if it did not grow very much, it would be better than a benefit that was small the first year and then grew dramatically.

So there are still areas, certainly, that we do not fully understand. There is uncertainty in all of these estimates. A lot of that uncertainty, though, is in how the elderly will behave once you introduce this kind of benefit.

The CHAIRMAN. Whatever economic model you might say you used, and you do not need to describe that to us, but what would you say are the significant weaknesses inherent in a model, and what would be the implication of that weakness on your ability to accurately predict a prescription drug cost?

Dr. CRIPPEN. I would say that the single biggest question is what we do not know about utilization in the future. The second would be, of course, how the pricing would work: whether the increases in demand would automatically raise prices, whether you would be

introducing competition. The third would be who ultimately picks up the costs that are now currently being incurred for pharmaceutical benefits for the elderly. As we saw from the pie chart, two-thirds of the elderly are insured. But many of the uninsured find a way to at least fill some prescriptions.

So there is a great deal of spending out there now that would ultimately be transferred to the federal government if you introduce a pharmaceutical benefit through Medicare. And there are many things we do not know for sure.

In addition, many of the answers to these questions depend very importantly on the details of the plans: for example, how many cost-control tools the pharmacy benefit manager's (PBMs) have, what the qualifying criteria for the benefit are—all kinds of details that I cannot begin to describe to you because I do not even understand them all. But in this case, it is really very true that the details drive the cost estimates.

To me, a good way to think about potential exposure is to look at the total costs of pharmaceuticals for the elderly. Over the next 10 years, even without a Medicare prescription drug benefit, we expect that the elderly will use $1.5 trillion worth of pharmaceuticals. Any substantial subsidy that you are going to provide to that population means picking up a substantial piece of that $1.5 trillion.

The CHAIRMAN. One of these issues would be whatever cost management tools we use in estimating the potential cost of a drug benefit to the government, if they can make a dramatic difference. What tools, in particular, would be most critical to control costs?

Dr. CRIPPEN. The most evidence we have on that is what is currently being done in the private sector using pharmaceutical benefit managers, which most of the proposals Congress has looked at in the past few years would incorporate.

PBMs use a number of approaches to control costs, such as: promotion of generic drugs and use of drug formularies. They can also, of course, in the process catch some of the mistakes we currently worry about in pharmaceutical usage, and help with disease management. So there is the possibility of a fair amount of savings with a PBM-like tool.

Mr. WALKER. Mr. Chairman, I think one of the key questions there is, how do you design the prescription drug benefit? For example, to what extent are you providing access to prescription drug coverage at discounted rates, and to what extent are you subsidizing the payment for that drug coverage? There is a fundamental difference.

You might want to provide broad access for individuals to be able to purchase prescription drugs at discounted rates through leveraging the purchasing power of the Federal Government. On the other hand, you may not want to provide subsidies, except for those individuals who are need, based upon their financial condition.

What we do know is that the prescription drugs are the fastest-growing component of health care costs. What we do know is that employers will get out of this business very quickly with regard to their retirees if the Federal Government gets in it.

The CHAIRMAN. Senator Baucus, then Senator Gramm.

Senator BAUCUS. Dr. Crippen, I just wondered how much thought you had given to the type of drug benefit that could be provided on a universal basis from $153 billion over 10 years, essentially the President's proposal?

Dr. CRIPPEN. Fortunately, Senator, we are not in the policy business.

Senator BAUCUS. But you are in the numbers business.

Dr. CRIPPEN. Yes, we are in the numbers business.

Senator BAUCUS. You are smart. You have looked with this. You have come up with all kinds of numbers over there.

Dr. CRIPPEN. If I am smart, I will not answer this question.

Senator BAUCUS. Yes. Right. [Laughter.] You are pretty smart. [Laughter.]

Dr. CRIPPEN. I will meet you halfway, then.

Senator BAUCUS. Realistically, what kind of a deductible, what kind of a stop-loss? Just ball park numbers here, with $153 billion, 10 years, for universal coverage?

Dr. CRIPPEN. It is really impossible to answer your questions without a lot more specificity because there are trade-offs between the cost of the Medicare benefit, the size of the low-income subsidies, and how many people you include. But in looking at the totality of it, funding of $150 billion would probably mean a pretty targeted benefit.

Senator BAUCUS. I am talking about universal. Assuming universal.

Dr. CRIPPEN. With a universal approach, it would be a pretty thin benefit.

Senator BAUCUS. How thin?

Dr. CRIPPEN. Depending upon how you did it, over 8 years it would be 12 percent to 15 percent.

Senator BAUCUS. Ten years. I asked you, 10 years, $153 billion universal. That is my question.

Dr. CRIPPEN. The $153 billion is really an 8-year number because the benefit would not go into effect until 2004.

Senator BAUCUS. All right. Let us just take the President's proposal.

Dr. CRIPPEN. I am sorry—the President's proposal?

Senator BAUCUS. $153 billion.

Dr. CRIPPEN. Yes. Over 8 years.

Senator BAUCUS. Yes. Whatever.

Dr. CRIPPEN. I am sorry; maybe I have lost the train of thought of the question.

Senator BAUCUS. What kind of deductible would there be?

Dr. CRIPPEN. I frankly do not know—I mean, honestly. It is not just the deductible. There are so many moving parts here that you would have to tell me a whole lot more.

Senator BAUCUS. All right. But you said "fairly thin." So what do you mean by that?

Dr. CRIPPEN. If you are going to spread $153 billion, or $160 billion, over the entire Medicare population, it will not provide a great deal of benefit for any one person.

Senator BAUCUS. I asked the question because many people suggested, if it is thin, it will not be utilized. It is just a waste of time.

Dr. CRIPPEN. Let me give you an example. If you decided that catastrophic coverage was one of the things you wanted to provide, you would not necessarily pay out large amounts a lot of money every year. Most beneficiaries would not receive dollars, but they would get insurance against some future exposure to high costs. Again, it really depends on what you are trying to do—whether you want to provide an insurance program or a benefit program. The details are deadly important.

Mr. WALKER. I think that is an important point. Again, if you want to enable all seniors, for example, to purchase prescription drugs at discounted rates based upon leveraging the purchasing power of the U.S. Government, that does not mean the government is going to pay for everybody, it means that it has leveraged it's purchasing power for the benefit of an Medicare beneficiaries.

Then you can end up targeting whatever dollars you want, $153 billion, $500 billion, whatever it is, to that segment of the population that you want to target it to that is most in need.

In addition, one of the things that you may want to consider, is should you provide very generous drug coverage at the beginning, especially in light of these financial projections for Medicare in the long term, or do you want to move in incrementally and consider providing some type of catastrophic coverage which is a true need?

People need to have protection against serious financial strain due to high drug costs. But that is very different than providing very generous drug coverage for everybody, including even some that, financially, do not need the assistance.

What policy options are there that achieve significant savings, but are not currently included in any reform proposals under consideration today? You two have thought about this. How do we save? Where do we save money, other than what has been discussed?

Mr. WALKER. I think, quite candidly, over time we are going to have to get to those fundamental questions that I mentioned. We are going to have to step back and say we have made more promises than we are going to be able to keep in the long-term. We have, in my opinion, on sustainability.

So, therefore, we are going to have to get back and we are going to have to say, all right, what do our people need in health care? Do they need, for example, access to guaranteed insurability at group rates? Do they need inoculations for children because of infectious diseases?

Do they need protection against financial ruin due to an unexpected catastrophic illness? Do they need certain of these things? Can we meet those needs? How much is that going to cost us? Then, how much more can we afford to provide beyond the need?

I think right now we have a situation where we are providing wants, in many cases, that we are not going to be able to sustain, yet we are not even meeting needs in other circumstances. So I think we are going to have to reconcile that. We are going to do some work on that at GAO. We are going to put together a framework to help.

Senator BAUCUS. That would be very helpful, because I think you are getting to the nub of the matter here. It is, politically, very difficult, clearly, but it is certainly responsible.

One very quick question here. What about reducing medical errors? Will that realistically save a lot of money or not? That is, an honest, good-faith effort to reduce medical errors.

Dr. CRIPPEN. From what we know, which is not a great deal, it is probably not a big money saver but more of a life saver. About half of such errors—or a little less than half, according to the Institute of Medicare report—are due to drug interactions, wrong prescriptions, or the wrong administration of prescriptions. As a result, you would not necessarily expect to save money with a prescription drug benefit. Obviously, the longer people live, the more they might actually cost Medicare. So I am not sure there is going to be much in the way of savings from reducing medical errors.

Senator BAUCUS. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. You bet.

Now, Senator Gramm.

Senator GRAMM. Thank you, Mr. Chairman.

I want to thank both of you for your testimony. I think that if add a prescription drug without dramatic reform in Medicare, that it is the legislative equivalent of criminal behavior. I think that the cost that will ultimately be imposed on the American people will be very large, indeed.

The problem, of course, is that there is a huge political base for prescription drugs. There is seldom any political base for reform.

I want to address this issue of utilization and cost management by just giving you some figures that, to me, are frightening. The last data we have on prescription drug expenditures by Medicaid beneficiaries who have the full ride, the government pays the whole bill, versus Medicare beneficiaries who pay their own pharmaceutical bill.

We have all talked about cost control measures and the government exerting its purchasing power, so you would expect that to affect these numbers. But here are the numbers. In the last data we have, the average Medicaid beneficiary with the government paying their pharmaceutical bills spent $777 per year. The average Medicare beneficiary paying their own bills spent $352.

So the person receiving full Federal funding is spending twice as much, even though supposedly the Federal Government is exerting a downward pressure on price with their so-called purchasing power that they get in purchasing in bulk or through negotiations.

When you look at prescription drug utilization, the numbers are even more stunning. The average Medicaid beneficiary—and these numbers are pretty similar with other people who have almost complete insurance coverage—gets 27 different prescriptions in a year, the average Medicare beneficiary without health insurance gets 12.7.

Again, the numbers are not identical, but the pattern is the same. If somebody else is paying, you spend more, almost twice as much, and you take almost three times as many different drugs.

Now, one thing that scares me to death, is when you look at these numbers—and we are talking about, the Federal Government is now going to begin to pay these bills.

I think that raises very real questions about utilization and the effectiveness of cost containment, especially—and this is what you

were getting at, Mr. Walker—unless you have deductibles and co-payments. Those are effective cost containment measures.

So, I wanted to get each one of you to respond to those concerns, if you could.

Mr. WALKER. First, obviously, the health status of individuals who are covered by Medicaid is likely to be significantly different than the health status of others.

Senator GRAMM. But employer-sponsored, and you would assume if you work for a corporation that has got enough money to fund prescription drugs in retirement that you probably have been higher income and higher education, they are spending $732.

Mr. WALKER. I think there is no question, Senator, that if you do not have adequate incentives for individuals to control utilization, and if you do not have adequate transparency with regard to the true cost of health care, you are not going to be able to control the costs. You are not going to be able to do it.

So a lot of it has to do with, what do you want to try to do? Do you want to provide access to health care at group rates? Do you want to pay for part of it? If so, for whom do you want to pay it, what type of deductibles, what type of co-pays, what type of limits? Or, conversely, do you want to start with catastrophic, see how that goes, and then see how much further down you are able to go that we could afford over time?

Senator GRAMM. Dr. Crippen, before I run out of time here, one of the things that bothers me, and I just want to give you an opportunity to talk about it, is where we are talking about this Medicare trust fund as if, somehow we build up this money, and as I look at the numbers, in the next 10 years we are looking at about $400 billion in this trust fund, and we are looking at spending $1 trillion out of the general revenue.

At least, as I recall, the only reason we have got a trust fund left, is we took the most expensive thing in Part A, home health care, and put it in Part B to basically help create this fiction.

I would like you to talk to us a minute about this trust fund that we talk about so much.

Dr. CRIPPEN. Senator, the trust fund and the reports we get on them, such as the one this week, are based on actuarial analyses, which are important and informative. But as General Walker also said, they are program-specific. In the case of Medicare, you are only looking at part of the program when you are looking at the Part A or Part B trust fund. In the case of Social Security, you are looking only at Social Security. The point is, such actuarial analyses are out of the context of anything. For example, they are out of the context of the Federal budget, and they are certainly out of the context of the kinds of budgetary rules and consequences that you know about. They are also out of the context of the entire economy. Actuarial accounting is thus interesting, but it does not tell you much about the consequences of a program's finances for the rest of Federal spending or the rest of the economy.

One way to think about it is that you could spend $5.6 trillion or cut taxes by that amount, and the Medicare trustees' report would not change because the actuarial accounting would stay the same. Nonetheless, there would be different consequences for those actions in terms of the economy and the rest of the budget.

Mr. WALKER. As you know, Senator, I was a trustee for 5 years, so I have dealt with these trust funds first hand. The trust funds are really more of a legal issue than they are an economic issue.

Senator GRAMM. Yes. There is no money there.

Mr. WALKER. There are no hard assets there. There are IOUs, there are government bonds that are backed by the full faith and credit of the U.S. Government. Those represent a priority claim on future general revenues, no more, no less. The fact of the matter is, there has been too much focus on the solvency issue and not enough on the sustainability issue.

The CHAIRMAN. We will reserve Mr. Jeffords' spot.

Now it is Mr. Breaux. If Mr. Conrad comes back, then he will be next. Then Ms. Lincoln, then Ms. Snowe, and Mr. Hatch.

Senator BREAUX. Thank you, Mr. Chairman.

Thanks to our two distinguished panelists. We have worked with them over the years on all of these issues, and they have made great contributions to the whole discussion on Medicare reform, and prescription drugs, in particular. We are still fighting and battling the war on how to get these costs down.

There was an interesting article in the New York Times magazine on Claritin the other day. Mr. Walker, I think it really gets to the point that you were making on the question of wants versus needs.

The same thing in Business magazine about GM's war on drugs, was Prilosec, about how the marketing of the drugs is contributing to the utilization of a particular type of drug, whether it may be necessary or not.

I am not sure how we handle that issue. Congress could clearly deal with the deductibility of marketing and advertising on prescription drugs if we wanted to do that. I am not sure that is the answer.

But this is a problem, is it not, with regard to utilization?

Mr. WALKER. It is a problem. I think one of the issues is, people have to have some economic stake in related decisionmaking. If you have somebody else paying versus who is getting, and if the individual who is getting does not have very much of a direct economic stake in that decisionmaking, you are never going to control utilization.

Senator BREAUX. That is a good transition to the chart that I have up there that we have been utilizing to try and explain how Breaux-Frist 1 and Breaux-Frist 2 handle the question of providing prescription drugs to Medicare beneficiaries. I would like to just outline it very briefly to both of you and have you comment on whether you think it is feasible or not.

The chart indicates a situation that I think all of us who have Federal Employees Health Benefit insurance should understand quite clearly, because that is how we get our drugs.

What I have tried to do in explaining this, if I walked into a drugstore in my hometown, along with my father who is on Medicare, and if my father walked into that drugstore and ordered his prescription, and the prescription was $100, my father pays $100 for that prescription because Medicare does not cover prescription drugs.

Unless he has bought another policy under Medigap, or if I am paying it for him, or somebody else is, or he is so poor that Medicaid covers it, he has to give the drug store and the druggist $100 for that prescription.

If I walked into the same drugstore with him and got the exact same prescription, because I have the Federal Employees Health Benefit insurance I do not pay $100 because I am part of a plan that gets a volume discount, which is normally about 25 to 30 percent. The price, with that discount, is $70 for me. But I do not pay $70 either, because I have Federal Employees Health Benefit insurance, which the government pays a large portion of.

The plan that I picked is one that has a co-insurance requirement which, David, you just mentioned. So I walk out of that same drugstore that my father paid $100 for a prescription, and I get the same prescription, and I pay $35 for it because of the volume discount and because my insurance pays everything but my 50 percent co-insurance requirement.

Now, under the Breaux-Frist 1, we make that type of insurance available to Medicare beneficiaries by guaranteeing that for everybody the government subsidies a portion of that premium, 25 percent subsidy, up to 135 percent of poverty it is 100 percent, and between 135 and 150 it is a graduated-down level.

We also require that people purchase it when they are eligible to obtain it to encourage more people into the insurance pool so we will have the largest number of people participating in it. A one-time enrollment option, is what we call it.

We also require government reinsurance to help on catastrophic costs above a certain level that the government would have to pick up a portion of to encourage companies to participate in that type of plan.

So we guarantee a government percentage payment for everybody, 100 percent for low-income people, we have a one-time enrollment provision to encourage more people to get into it, and we have a reinsurance government program to help with catastrophic costs. Can both of you comment on whether this type of proposal is feasible, or off the wall, or what?

Mr. WALKER. I will comment first. First, I think this is an excellent example, to reinforce a couple of important points. An individual out on their own might have to pay $100. The Federal Government, on its own, could end up trying to leverage its purchasing power to make sure that everybody is eligible to get the $70. That is an accomplishment right there. Everybody would be able to get the $70.

Then the question is, who do you want to subsidize, and to what extent? In your proposal, you are proposing to subsidize everybody, to a certain extent. It is debatable as to whether that is good or not, but that is what you are proposing.

But what you do have is a co-insurance provision, which I think is important because individuals need to have an economic stake in the decision. If they do not have an economic stake in the decision, you are not going to be able to effectively control utilization over time.

Dr. CRIPPEN. I think, Senator, we have previously discussed one of the important details, or a set of details, which you and I do not

have time to go into today, that has to do with how the elderly would react, how much they would use.

Ultimately, too, there is the issue that some folks' discounts are other folks' costs. If your father is currently paying a higher price than you are, he may be essentially paying part of your price. How much the cost subsidies go back and forth in this system is not clear.

Senator BREAUX. I understand that. But the point is, from an economic standpoint, what is your comment on this type of an insurance, subsidized government insurance plan for Medicare beneficiaries? It is clear that people who pay cash pay a lot more than people who do not pay cash, than they have if paid for by a third party. There is no question or dispute about that.

If you are a cash payer, you are paying a lot more than someone who has a third party paying for them. But the question is, from a budgetary standpoint and an effectiveness standpoint, the concept of what we have as members of Congress, is that something that is conceivably transferred to the Medicare beneficiaries?

Dr. CRIPPEN. I think the answer is yes—both mechanically and economically. We do not know what the budgetary consequences would be.

Senator BREAUX. Thank you.

Thank you, Mr. Acting Chairman.

Senator BAUCUS. Thank you very much, Senator.

Next on the list, is Senator Lincoln. Actually, it is Senator Snowe.

Senator Snowe, you are next.

Senator SNOWE. I want to thank you very much for being here today. Obviously, I think both of your testimonies, once again, create the foundation for some of the challenges that we are going to have to grapple with in the future.

Mr. Walker, you mentioned the fact that it should be sustainability that we should be focusing on, not the solvency, of the trust fund. I know in your testimony you indicated that it would require ample time to phase in reforms to have an impact on the sustainability.

Can you give us a window of what we are talking about? I think, clearly, between the prescription drug program, which I happen to think is very compelling. I think we have to address that issue here and now.

Some have referred to the political costs. Well, I think we ought to look at the cost it has represented to the seniors who are without any insurance coverage whatsoever. Obviously, we have to grapple with the other issues concerning the long-term reforms of Medicare.

Could you give us an idea of what we are talking about in terms of policy changes that would have an impact on Medicare, for what period of time? When would we have to take actions to affect what will begin to happen between benefits and revenues in the Medicare program starting in 2016?

Mr. WALKER. First, let me give you the idea of the magnitude of the unfunded liability for Medicare, just Part A alone: $4.6 trillion. We would have to have $4.6 trillion today and invest it just to

cover the next 75-year imbalance. Then there are huge imbalances 75 years out.

There is no question that the Congress is likely to do something on prescription drugs. I guess what I would say, is this. Incrementalism comes two ways. We are not going to be able to close that $4.6 trillion gap in one fell swoop.

We are going to end up having to do a number of things over a period of years, an extended period of years, in order to be able to do that. Some of it may be on the revenue side, some of it is definitely going to have to be on the benefit side and the management side.

But one of the other things that you may want to think about, is also incrementalism from the standpoint of any additional new benefits. You may want to think about whether you can afford to do everything that you would like to do, or want to do, in light of these long-term fiscal pressures, and whether or not it might make more sense to focus on the truly needy, and target whatever is being done to the truly needy at first and see how it goes before you start opening it up.

The simple fact of the matter is, if you look at what is going to happen in the future, the percentage of the budget represented by Medicare, Medicaid, and Social Security, based on the projections we showed a little earlier, is going to crowd out all Federal discretionary spending in the future.

Senator SNOWE. Is that 2030?

Mr. WALKER. 2030. It is going to crowd out about half of it by 2030 if you save every penny of the Social Security surplus, but spend the on-budget surplus. I mean, we are talking about huge imbalances here.

So major incremental changes over time will be needed to close the $4.6 trillion gap. Some of the concepts we have talked about here are probably going to have to be looked at. But you also may want to think about incrementalism from the standpoint of the prescription drug benefit.

For example, do you want to provide the opportunity for every senior to purchase group prescription drugs at a discounted price? That is a good thing. But then who do you want to end up providing subsidies for, and how much of a subsidy? How can you structure that in a way to control utilization through co-pays?

Premiums will not control utilization. That is not going to do it. If anything, that is going to encourage people to use it more because they are paying their premium and they want to get their value for the benefit. If there is one thing, frankly, that can bankrupt us, it is health care.

Senator SNOWE. So the deducibilities and the co-pays would be one way of controlling the costs.

Mr. WALKER. Yes, they would be. I would suggest, as in my testimony, that at least, hopefully, what you can do is design this in a targeted way based on need versus want, and hopefully couple it with some other reforms that will not make the long-term situation worse.

That does not mean you are closing the $4.6 trillion gap, but at least hopefully you are not increasing the $4.6 trillion gap. Again,

recognizing that these reforms are going to have to be done incrementally over a number of years.

Senator SNOWE. Is there a way of targeting the one-third of the Medicare beneficiaries, without creating imbalance in the rest of the program, discouraging other types of coverage being offered? I mean, it gets back to the universal concept of the Medicare program.

Mr. WALKER. It is all what you mean by universal. How do you define universal? You could choose to define universal as universal access to discounted drug prices. Then the second issue is, how much subsidy are the taxpayers going to provide?

Part of the problem is, who is getting and who pays is very different. With the demographic tidal wave that we face, the people that are getting it today are not going to be the ones who are paying. The people who are going to be paying are the baby boomers and the Generation X'rs. Really, the Generation X'rs, our kids, and eventually grandkids in Generation Y. That is who is going to be paying it.

Senator SNOWE. Thank you.

Senator BAUCUS. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

Arkansas ranks number one as the State with the highest poverty rate among seniors, so I am very concerned about, obviously, the rising cost in prescription drugs.

Dr. Crippen, based on your analysis of drug prices, which you have done a great deal of, what are the main reasons for the double-digit inflation rates for prescription drugs?

Dr. CRIPPEN. There are several reasons. Probably the single biggest one is that more prescriptions are being written and filled—simply, utilization of existing drugs. Second, existing drugs are being replaced therapeutically by new drugs, which tend to have higher prices. So there is some price effect there.

The double-digit increases in spending are probably produced by a combination of those two factors. There is some evidence that the increase stems more from utilization than from prices, but there is also some evidence that it derives more from prices than from utilization. It is obviously those two pieces.

Senator LINCOLN. But, overall, prices are rising at a higher rate than inflation, correct?

Dr. CRIPPEN. Certainly, the costs of prescription drugs are. Some prices of specific pharmaceuticals are rising faster than inflation, but the costs are the combination of utilization and price, so again, if you are looking at current drug therapies being replaced by new drugs, the price of the new drugs is certainly higher.

Senator LINCOLN. Yes. But there is definitely an increase, even in existing drugs.

Dr. CRIPPEN. There is some increase, yes. It depends a great deal upon when a drug becomes eligible for generic status. Once that happens, there is a fair amount of price competition.

Senator LINCOLN. Right. Well, I certainly understand in terms of new drugs on the market, the increase in prices. But it was my understanding that existing drugs are rising at a higher rate than inflation currently, and I have some concern over that.

Dr. CRIPPEN. It depends, again, on which sector you look at. For example, within the Veterans Administration, which has a very strict formulary and negotiates prices, there is some evidence that most of their cost increase is due to utilization.

Last month, the health director of General Motors testified on the other side of the Hill and said their average annual increase over the past 3 years has been 19 percent. Much of it is due to more prescriptions being written, some of it for the advertised drugs. That point was raised earlier. A lot of it is due to replacement of current therapeutics with new drugs.

Senator LINCOLN. Along the lines of what Senator Baucus asked, he basically said, what Medicare reforms are out there to be had in terms of savings that we can see? I guess I would ask it in another way, since you are in the position you are in. What actual Medicare bills, reform bills, have you scored that achieved significant savings?

Dr. CRIPPEN. We scored a couple of proposals last year that had some expansion of competition—for example, even on pharmaceuticals, in which the incentives are properly structured, pharmacy benefit managers could save some money. We also believe that if there was more competition among providers for Medicare recipients, there could be savings.

Senator LINCOLN. Which bills were those that actually achieved significant savings?

Dr. CRIPPEN. I think they were the Administration's proposal and Breaux-Frist 1.

Senator LINCOLN. The administration's proposal and which?

Dr. CRIPPEN. Breaux-Frist 1.

Senator LINCOLN. General Walker, my concern, in your comments about the surplus, if the health insurance trust fund, the gap that you talk about that is continuing to grow—and I certainly understand the need for both solvency and sustainability—but if that continues to grow, isn't that somewhat of a compelling reason to protect a portion of that budget surplus? We have got a gap there that we have got to shore up.

Mr. WALKER. As you may know, Senator Lincoln, we have testified on a number of occasions, as an institution and myself as an individual, about the different array of choices you have for the surplus. Clearly, the least risk is to pay down debt. The highest risk is to increase entitlement spending. That is the highest risk. There are a number of things in between.

You can end up prefunding existing obligations, obviously certain types of tax cuts are different than others, certain types of spending is different than others. If it is one-time spending for a particular investment or a particular item, that is obviously less risk than a baseline increase.

Senator LINCOLN. But moving those trust fund dollars—or Senator Gramm did not want to call them trust fund dollars—into a contingency fund, does that not create a risk for that gap?

Mr. WALKER. The question is, what happens with the contingency fund? If the contingency fund is used to pay down debt held by the public, that is obviously all right. If the contingency fund is used for increased spending, that is higher risk. If the contin-

gency fund is used for additional tax cuts, that is higher risk. So, it really depends upon what happens.

Senator LINCOLN. I have been in the ring where it has been offered to farmers, and a couple of other folks, too, who are seeing some real needs down the road.

Dr. CRIPPEN. One thing we have tried to say, both General Walker and I, Senator, is that the actuarial analysis provides a lot of important information. But the balances themselves are not really available to finance benefits when you and I retire.

What is in the funds is going to be cashed in at the Treasury, at which time the Treasury will have to raise taxes, increase borrowing, or cut other spending in order to redeem those notes. So it is not the balances in the trust funds that will really finance your retirement and mine; it is our kids, and the size of the economy, and what they are both doing at that time.

Senator LINCOLN. That is exactly right. If they are presented with even further deficits that have been created from other spending mechanisms that have been promised from a contingency fund that actually should have been set aside to be able to provide for that insurance trust fund, you are exactly right. I do not disagree with that.

But when you talk about the difference between a trust fund versus claims on future assets, I have got to think that we could prepare better for that.

The CHAIRMAN. Senator Lincoln, it is rude of me, but I do not think you want to miss a vote.

Senator LINCOLN. No, sir, I do not.

I thank the gentlemen for their testimony.

The CHAIRMAN. If somebody wants to, for the record speak to her question even though she is leaving, please do it.

Mr. WALKER. I will do it, real quickly. I think on March 30 of this month, we are going to issue the consolidated financial statements of the U.S. Government. Actually, Treasury will issue it, and we audit it, as the GAO.

If you look at those financial statements, you will find out that the trust fund assets are nowhere in the financial statements, meaning the balance sheet. They are not assets. Why, because the right hand owes the left hand, so, therefore, it is eliminated.

All the more reason to recognize that, while they do have legal significance and they do have a moral significance, they do not have economic significance, and economics is what matters.

The CHAIRMAN. My question on a second round, Mr. Walker, gets back to what I have tried to show in my opening statement and some other comments I made about Part A and Part B being very complicated for the public to understand.

Getting back to the fact that you are making some compelling points on the question of how to assess Medicare's fiscal condition, this is something that you have written: "Clearly, it is total program spending, both Part A and Part B, relative to the entire Federal budget and national economy that matters. This total spending approach is a much more realistic way of looking at the combined Medicare program's sustainability."

So do you have any ideas on alternatives to the current Part A—only solvency test, since that test is so misleading?

Mr. WALKER. Well, obviously, under Breaux-Frist 1, for example, one of the things that they proposed is to consolidate A and B and to have a measure that would be the percentage of costs that are being paid for out of general revenues. I think they are proposing 40 percent.

That would be one alternative measure. I would respectfully suggest that. But, in addition to that, if we want to deal with the sustainability issue, we will also have to consider the percentage of the Federal budget that this program represents, and potentially the percentage of the economy. But, at a minimum, a percentage of the budget.

The CHAIRMAN. Dr. Crippen, I want to make sure that I understand your comments on Medicare spending projections under current law. You noted that Medicare spending grew at an average of 10 percent in the decade before the 1997 Balanced Budget Act, but that spending has grown 3.4 percent per year for fiscal years 1998 through 2001, closer to the overall level of inflation of the economy.

I understand that, even without any further legislation on our part, Medicare spending is projected to shoot back up by 10 percent this year, and by 7.7 percent average over the next decade.

Is this correct, and could you further explain the coming trend? I ask you, because it is highly relevant to the pleas for further provider relief this year.

Dr. CRIPPEN. Yes. First, you are correct, Mr. Chairman, that those are our assumptions and estimates. The reason that Medicare spending will bounce back up, is that some of the cost reductions that got us down to the 3-percent-plus range were one-time or temporary savings.

Second, as you well know, the Congress has passed two bills to replace some of the savings that the Balanced Budget Act of 1997 (BBA) imposed, and many of those expenditures, those outlays, are just coming home to roost and are going to show up in the next couple of fiscal years. So far, in fact, we have not seen very much of an effect from the bills to replace what the BBA cut. We certainly could not yet have seen any effects out in the real world, so it is a little hard to understand how some people could argue for reversing more of the cuts when those effects have not really gone into place.

Third—and General Walker can speak to this issue more than I can—his agency, the Health Care Financing Administration (HCFA), and others have been investigating whether patients are not receiving care. For example, are they being denied home health services? Are they being denied access to skilled nursing facilities?

No one, so far, has found that patients are being denied health care. My guess is that your primary objective is to make sure that payments are adequate and that the Medicare population receives benefits.

Mr. WALKER. Mr. Chairman, I think one of the real challenges here is, if we look at the size of health care as a percentage of the budget and the economy, it is amazing how inadequate the data that we have to make informed decisions is. It is several years old, and it is not usable.

One of the things that needs to happen in order for the Congress to be able to make informed judgments, and in order for HCFA to

be able to effectively administer the program, is to somehow figure out how they can get access to more timely, accurate, useful information to be able to separate assertions from fact, to be able to really target relief to people who really need it versus those who want it. Right now, the agency does not have the data to be able to do that.

The CHAIRMAN. When the agency does not have it, and this could be true of either agency, are you also saying that there is not a database any place in the private sector that has studied it, given some study to it, has information on it, the collection of information that would supplement what you do not have, or it just does not exist at all?

Mr. WALKER. Not what we need, Mr. Chairman. As you know, unfortunately there is a conflicting interest. There is a conflicting interest between the payor, which in this case is the government, through HCFA, and the providers. We do not have a mutuality of interest.

So, therefore it is very, very important that the payor, whoever that may be, the government, the employer, whomever it might be, have accurate, timely, and useful information, which it does not have right now, in order to be able to ascertain which provider claims for relief are merited and are based on need versus which ones are based on what and are assertions that are unfounded. That is some of the work that we have done. Bill Scanlon, in our health group. We found that some are truly in need, but many are in the want category.

Dr. CRIPPEN. Senator, the data for these kinds of programs tend to lag quite a ways behind, as General Walker said.

The CHAIRMAN. Wherever it is, government or any place else. All right.

Dr. CRIPPEN. The most current source of rich data is held by the contractors, and we are not getting it collected in any systematic way. But the lagged data still give us some indication.

Part of the story of the lower costs in the late 1990's was that the Clinton Administration had made a new effort—at the Congress's behest as well—to try and combat waste, fraud, and abuse. One of the big reductions in costs during that period came from inaccurate coding of diagnoses. The case mix actually changed from more expensive diagnoses, which had been the trend, to less expensive diagnoses. One of the things that also happened was a change in psychology, if you will, under the pressure of being scrutinized. We can tell that from the data now. But again, that was the late 1990's. We cannot tell what is happening today.

I might suggest, though, that you have some data that none of us have. Are you hearing from patients or constituents that these payment reductions are denying them access to health care?

The CHAIRMAN. We are more apt to hear from providers than from patients.

Mr. WALKER. That is a want side too.

The CHAIRMAN. Senator Hatch?

Senator HATCH. Welcome to both of you. We are happy to have you here.

Many of us still remember the Medicare Catastrophic Coverage Act of 1988. Certainly, I do. Let me assure you, those of us who

served in the Congress at the time cannot forget the images of senior citizens jumping up and down on former Chairman Nanny Rostenkowski's car. It was a sight to behold, I thought. They thought they had to pay for their prescription drug coverage.

When they found out they actually had to pay for it, they were not very happy. Of course, that was a very sorry interlude in all of our lives.

A recent poll by Harvard University and the Kaiser Family Foundation found that more than 60 percent of the adults polled said that they would support a drug benefit that provided Medicare beneficiaries with money to purchase prescription drug coverage. Interestingly, but not surprisingly, that number fell to 40 percent when respondents were informed that the plan would cost them more money.

Now, I think what I am asking is, regardless of whatever plan Congress approves, do you believe that, ultimately, beneficiaries will see their costs, whether in co-pays, deductibles, or higher premium costs, go up?

Dr. CRIPPEN. The choice, Senator, is between only two sources of money: one is current workers, and the other is the beneficiaries. Which one depends upon the program design, but some group is going to pay the bill.

Senator HATCH. The cost is going to go up.

Dr. CRIPPEN. And somebody is going to pay it. You can transfer it around, but you cannot eliminate it.

Senator HATCH. It just seems to me, at the end of the day, that beneficiaries will likely see their costs increase. There is no way that we can do that. That is, provide the drug benefit without that consequence.

Dr. CRIPPEN. The only way in which we do not pass on more costs to our kids, Senator, is to make recipients—make us, when we retire—pay the full freight. Otherwise, we are just transferring the cost to the next generation.

Mr. WALKER. Obviously, Senator, if people can get a benefit that they pay little or nothing for, then they want it. If they get a benefit that they are going to have to pay something for, as you properly illustrate, there is a drop-off as to how many people want it.

One of the things that is going to have to happen in order to control overall costs, is to have some type of co-pays or whatever in it in order to control utilization. If you do not have that, history has shown, you cannot control overall costs.

Plus, as we mentioned earlier, the unfunded liability for Medicare Part A alone is $4.6 trillion. That cost has got to be borne, most likely, by future taxpayers, our kids and grandkids, if we do not do something about it.

Senator HATCH. Unless we do something about it.

I have to say, I found the testimony from both the CBO and the GAO quite sobering. I am strongly supportive of a Medicare prescription drug benefit. However, according to your testimony, Dr. Crippen, even a catastrophic benefit, which is probably one of the least expensive proposals, has the potential to be extremely expensive.

Dr. Crippen, you state that if only drug spending over $5,000 a year were covered, costs were in 2011 would be about $365 billion, right?

Dr. CRIPPEN. Over the next 10 years, yes.

Senator HATCH. Right.

Dr. CRIPPEN. Over 10 years.

Senator HATCH. That estimate is much higher than even I ever imagined, and I knew that the plans that had been advanced by Senator Kennedy and others were off the charts, if you really look at them.

One legislative proposal that you did not mention is the plan which limits prescription drug coverage to low-income Medicare beneficiaries who are not eligible for Medicaid, but do not make enough money to afford the Medicare supplemental policies.

Do you have a rough idea? Even a rough idea would be helpful to us today—of how much it would to provide coverage only to low-income beneficiaries, or people below a certain level of poverty, you pick it?

After listening to both of you discuss the projected spending for the Medicare Part A and Part B programs, I believe that this is a proposal that maybe we should study in more detail.

So do you have any estimate for that?

Dr. CRIPPEN. We have a rough notion. People with incomes between 100 percent and 200 percent of the poverty level are the group who are least likely to be covered by Medicaid or, because they cannot afford it, to have employer-sponsored or Medigap coverage. Nevertheless, within that population, there are still some people who are insured in various ways. That group of people probably has overall annual drug expenditures in the neighborhood of $20 billion to $30 billion today. Covering those who were currently uninsured would probably be a number less than that.

Senator HATCH. Over an 8-year period it would be, what did you say, $130 billion?

Dr. CRIPPEN. At approximately $20 billion to $30 billion a year, it would be $200 billion over the period for everybody in that group. But some of them are insured.

Senator HATCH. Just to cover those who we consider most needy who are not covered by Medicaid.

Dr. CRIPPEN. Right—those who have incomes that are between 100 percent and 200 percent of the poverty level.

Senator HATCH. Right.

Dr. CRIPPEN. That $200 billion is a very gross number.

Senator HATCH. When we talk about universal coverage, we are talking about the potential of upwards of $1 trillion over a 10-year period.

Dr. CRIPPEN. Very easily, as you can see. It depends critically upon what the details of the benefit are and whom you are targeting, but universal coverage, without targeting, could easily cost $1 trillion.

Senator HATCH. This is pretty sobering testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hatch.

Now I would call on Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I want to ask, as I am wont to from time to time, sort of a philosophical question, either one. The discussion around this table is always, we cannot do this because it is going to cost too much. You present the $4.6 trillion, a staggering figure. Therefore, the reaction is, we have to pull back. We have to do that. Which brings into question, how then does one value health care? How does one value health care?

We have decided in this country that everybody is going to get an education. One can argue about whether one likes public education, private education, parochial education, et cetera, or not, but everybody gets one. There is not a debate about whether or not we get an education because it might be too expensive, or because we might have to spend too much on this or that. We just do it.

Now, you can argue, I suppose, that there are very successful people in this world, in this country, who have received very little formal education. You probably cannot argue that there are people who get leukemia, or whatever, at substantial levels at the age of 12 or 13 who go on to make much of their lives.

I think that is a fair question to ask. It is a fair question to ask. In other words, you can make it without an education, but you cannot make it without health care. We say you have to have an education. The country so mandates. States mandate it, the country mandates it. Nobody even questions it, you have to have it. Truancy officers, all of that.

Health care? Well, if it is expensive, yes, you can get as much as you can get. If it is cheap enough, you can have as much as you want. If you are rich enough, you can get all that you want. But if you fall somewhere in between, it is an open question.

So the question I would posit to you, is are we not really talking as much about, one, a value system of what is important in America? I would say it was beyond outrage that children would not have health care.

I would also say it is beyond outrage that children would be denied the chance to go to school, but I do not have to say that because children are not denied the chance to go to school.

So I would like you to reflect on that a little bit. I am not on the Labor and Education Committee, but people do not come in and say, well, we are going to do this on education, therefore, since that is too expensive, we are going to have to increase the co-payments and deductibles, we are going to have to do this or that, or we are going to have to sequentialize the prescription drug benefit, or the math course. We will have to give them half of a math course. We do not do that.

Now, why is it that we prefer to say that health care is expendable or rationable because of costs, but we do not ask that about other things?

We have seven Naval fleets, I would believe. We would have an eighth, if it were not for the State of Israel. We would have to have one in the Eastern Mediterranean, but because they are there we do not.

So we do not ask that question as much about defense. We are inclined to ask it less. This gets asked within Armed Services, and they work those things out. One can then talk about missile de-

fenses, and things of that sort. But there is a general feeling that the Nation has to be defended, that people have to be protected.

But health care, somehow, does not really have to be for everybody unless you can prove that you can afford it and do not really take a whole lot of chances on that. I find that troubling, and am interested in your reactions.

Dr. CRIPPEN. Fortunately, you folks have to speak to the issues of rationing and the values of the country and how they are balanced in a budgetary process.

I would say two things, though. I do not mean to be defensive, and certainly not on the General's behalf, but we need to carefully define our problems. Using the number of uninsured people as a surrogate for lack of access to health care, as you know better than I, is not necessarily an accurate indicator. We know that there are many uninsured nonelderly people—40-some million by one census count. But that same survey shows us that the average period that those folks are uninsured is seven-plus months. So, it is not a case of 42 million people being chronically uninsured and therefore not having access to health care. We need to be careful about how we measure the problem.

Equally important, and this is what I have been trying to say, is that if you provide a targeted benefit aimed at the problem you are talking about addressing, it can be less expensive for taxpayers and—more important—for our kids.

What we are talking about adding here is a benefit that we will finance for our parents, as we are now doing, but that our kids will have to finance for us.

I think the General and I are trying to say that the more targeted you can be in whatever you are doing—whether it is health care or something else—and less universal, then the less burden you are going to place on current workers and, more important, future workers.

Mr. WALKER. Senator, I think you make some excellent points. I think it is a question of values. It is a question of choices, of priorities. It is a societal decision, and we need to have a debate about that.

I would also agree with you that the point that you make is right in line with one of the things I tried to make in my testimony. We need to have an informed debate about wants versus needs, versus what is collectively affordable, especially in light of the demographic tidal wave which is going to hit us starting in about 11 years, and the profound fiscal, budget, and economic implications of that.

I would respectfully suggest that there are certain need aspects of health care, that you could make a very compelling argument to say that it ought to be universally available, that certain types of health care ought to be universally available. There are segments of our society that do not have that right now.

On the other hand, I would also respectfully suggest that, in some areas, we are into the want category, big-time. We promised a lot of wants that we are not going to be able to sustain without hugely increasing tax burdens.

Now, maybe the American public will want to increase their tax burdens along the lines of what our charts show, which are huge.

It is approaching levels close to many countries in Europe. Historically, they have not. We need to make an informed decision about that. You do.

There needs to be an informed debate about that. That is all we are trying to say. You can do a prescription drug benefit, but it would be prudent, in our view, to consider the long-range implications, not just the short-term money but the long-term implications, and it would also be prudent to possibly do things incrementally, maybe focus on access, first, focus on those truly in need versus those who want it, because of the long-range challenges we have.

Senator ROCKEFELLER. Thank you.

Senator BAUCUS. Thank you very much, Senator.

Senator Graham?

Senator GRAHAM. According to CBO, this year we will spend approximately $217 billion on Medicare. That number, 10 years from now, rises to $436 billion. The prescription drug plan that the Democrats are proposing is estimated to have a price range in the $320 to $330 billion range over 10 years, which would be approximately a 10 percent addition over 10 years to what your current projections are.

Is that not more or less in line with what prescription drugs as a percentage of the total health care expenditures of the country are?

Dr. CRIPPEN. Total expenditures for the whole country are a little less than that figure; for the elderly, they are more. I can be more precise and would be happy to do that in writing.

Senator GRAHAM. The point I am making is, at that level of $320 to $330 billion over 10 years against a 10-year projection of current expenses, which averages out close to $300 billion a year, on average, over the next 10 years, is within what other segments of the population are spending on prescription drugs is not an unreasonable percentage of health care expenditure.

Dr. CRIPPEN. That amount would provide, Senator, by our reckoning, for about 20 percent of total elderly spending on pharmaceuticals over the next 10 years. So if you applied it across the board, with no other criteria, it could pay for about 20 percent of the $1.5 trillion we expect the elderly will be spending.

Senator GRAHAM. I am approaching it from the slightly different perspective of saying, in terms of the percentage of overall health care expenditures for all Americans, that portion of those expenditures which is represented by prescription drugs, the addition of the prescription drug benefit that is being proposed is approximately the same relationship as the general population of America is now spending on prescription drugs, and we are doing this for a population which has a greater propensity to use prescription drugs. I say that to support the thesis that this is not a wild, out-of-control, unreasonable proposal that is being made, as maybe some have suggested.

I tend to agree with the statements that each of you has made, that it would be desirable to have this addition of prescription drugs done in conjunction with some overall Medicare reform, which, among other things, would focus on issues of financial sustainability of the plan.

I was out of the room when this question was asked, Dr. Crippen. But I understand, in response to a question by Senator Lincoln, you indicated, when asked which of the various proposals that have been introduced would have significant savings, that Breaux-Frist 1, which was the Breaux-Frist introduced in 1999, would have significant savings. Is that correct?

Dr. CRIPPEN. I think we came up with Breaux-Frist 1, but I am not positive.

Senator GRAHAM. Could you assess, what would be the savings of Breaux-Frist 1?

Dr. CRIPPEN. We do not know at the moment.

Senator BAUCUS. Yes. I have sent a letter requesting those scores, and so far we have not received them. I think the Chairman did, too.

Senator GRAHAM. But you think that they are going to be significant?

Dr. CRIPPEN. Frankly, I cannot say at the moment. I do not remember. The Clinton Administration's proposal had some savings, but not a great deal. There are some techniques and methods that we certainly think will save money, such as introducing competition and using PBMs. However, I do not have the magnitudes of savings available for any of those specific proposals.

Senator GRAHAM. Will you have some further analysis?

Dr. CRIPPEN. Yes. In fact, we have a number of proposals in front of us that we have been asked to look at, and we are working on those now.

Senator GRAHAM. I was going to ask the same question of Mr. Walker. Of the various proposals that are on the table, have you done an assessment of what their potential savings would be?

Mr. WALKER. Well, we rely upon CBO to give us the savings numbers. We have done an analysis of the former President's proposal, as well as Breaux-Frist 1. We have also done some work looking at Breaux-Frist 2, which is getting somewhat closer to the former President's proposal.

We have noted that it would be a step in the right direction, that there might be some savings, but we rely upon our colleagues at CBO to give us the numbers.

Senator GRAHAM. Does Breaux-Frist 1 not primarily focus on the Medicare Choice Plus aspects of Medicare?

Dr. CRIPPEN. It apparently is more than just that.

Mr. WALKER. They both rely heavily on increased competition to the non-fee-for-service portion of Medicare, and that is why one of the points that we think is important is, you can achieve some savings through increased competition, through increased cost sharing and incentives to control utilization, but we also need to focus on basic fee-for-service Medicare, because no matter how you look at it, over a number of years into the future, a vast majority of the population is likely to be covered under fee-for-service Medicare.

Senator GRAHAM. As I understand it today, about 85 percent of the Medicare population is in fee-for-service?

Dr. CRIPPEN. That is correct, Senator.

Senator GRAHAM. And is that not a higher percentage than it was 2 or 3 years ago?

Dr. CRIPPEN. Yes. The growth has stopped and may actually be declining currently, but, yes, it is higher.

Senator GRAHAM. I would be very interested in getting a follow-up analysis of what the potential savings under the various proposals would be.

Senator BAUCUS. It is my understanding that Breaux-Frist 1, theoretically, will have some savings. It is my understanding that Breaux-Frist 2 will have, theoretically, virtually no savings. Under 1, an independent analysis that I am aware of is that Breaux-Frist 1's savings, over 10 years, is between $50 and $60 billion.

I might compare that with your estimate—I have forgotten which one of the two of you in your testimony just now—that said that Medicare, by 2011, in that one year only, just that year only, will cost, according to your estimates, $436 billion.

So compare 1 year at $436 billion, that is 1 year of Medicare expenditures, with the outside analysts' view of Breaux-Frist 1 of $50 to $60 billion over 10 years. So, I will not say it is pocket change, but it is not going to really address the "solvency/sustainability" problem.

Dr. CRIPPEN. There was another proposal that I think may not even have been introduced and that we did not score, the Breaux-Thomas proposal, which came out of the bipartisan commission on the future of Medicare. The actuaries did look at that and gave it a fair amount of savings.

Senator BAUCUS. If you could, I would be interested in getting that. You are a smart guy. [Laughter.]

Dr. CRIPPEN. I have heard that before.

Senator BAUCUS. If you can get those numbers back to us pretty quickly, we would appreciate it. I know Senator Graham would, in particular.

Mr. WALKER. I think another important thing, Senator Baucus, is if you look at the framework of Breaux-Frist, obviously it provides a framework in which you can make certain adjustments if you wanted to in order to reduce the costs, and possibly act incrementally.

For example, if you decided that you wanted to provide access to all seniors for discounted prescription drugs through leveraging the purchasing power of the Federal Government, that does not necessarily cost the government anything.

On the other hand, if you want to provide subsidies for those who are truly in need, then how you define those subsidies, how you target those, what percentage they are, can be played with to have a significant impact on what the savings are.

Senator BAUCUS. Right. I appreciate that. I am just trying to be intellectually honest here, and hope that everybody else is. I know everybody is, but I am just trying to help out a little bit.

That is, when you talk about Medicare reform, some people talk about competition, others talk about solvency. They are two separate concepts. Entirely separate concepts. Now, one might be able to help the other, but they are still entirely separate concepts.

I just hope, when somebody says reform, he or she indicates which of the concepts he or she is really referring to, rather than trying to lump them together. I have a hunch that some people intentionally lump to try to accomplish an ulterior objective.

Dr. CRIPPEN. I hope there are other options as well, Senator.

Senator BAUCUS. I agree.

Dr. CRIPPEN. Solvency is not one that I would encourage you to use at all.

Senator BAUCUS. Absolutely.

Mr. WALKER. Competition can be an element of reform.

Senator BAUCUS. That is what I said.

Mr. WALKER. But we have demonstrated, I think, that it is not nearly enough, given the delta that we are talking about.

Senator BAUCUS. Right. That is what I said. It is part of it, but let us be honest what we are talking about.

Mr. WALKER. Exactly.

The CHAIRMAN. I am done with my questioning. But in regard to the issue that these two gentlemen brought up about answering requests for costs, you are probably going to be called upon to cost a lot of items. Even on just this one issue of prescription drugs, different plans, you might think in terms of—I do not know how limited your resources are, how fast you can turn things around—but if there is going to be a problem, you ought to be very candid with us and tell us what time is involved, and how you handle the plans, what request has priority over what other request.

Because as we get into this, hopefully in this committee by July—now, some people are saying that is too doggone early for us to be dealing with this issue. But I would like to deal with this issue by July, because I am fearful, if we get into the fall for committee work, then we do not get anything done on the floor this fall.

Now, I think some of our leaders think that this ought to go over into next year. I do not think it should go over into next year. So that puts a squeeze on you. We cannot make judgments without your costing these out.

So be as candid as you can what the resources are, and what sort of priorities ought to be set. If you work for Senator Domenici, and Mr. Conrad, work it out with them, or whatever the case might be, so we are not left hanging. That is not a criticism, it is just a suggestion.

Dr. CRIPPEN. I understand and appreciate it. We can certainly tell you how we go about prioritizing things. Your committee, Mr. Chairman, is listed in the Budget Act as one of those we are supposed to respond to, and I hope we have been responsive and continue to be.

As I have tried to suggest, when these proposals are complete and in legislative form, they are very complex. The first thing that takes days for us is to figure out how they work. That done, we cannot just turn a crank and get a number. We have to change the modeling in order to reflect how we think the interactions work. So it takes a long time to do a single estimate. Obviously, we will be responsive to you and to Senator Baucus. If you have committee mark-ups or consideration coming, you need to let us know, and we will try to accommodate you.

The CHAIRMAN. All right. Thank you very much.

Now, all the questions have been asked. You might get some questions in writing. We would appreciate answers in a couple of weeks.

Thank you very much.

Our second panel is made up of Rick Foster, Chief Actuary, Health Care Financing Administration. He will discuss factors which will drive the anticipated growth of Medicare's spending, as is highlighted in the new Medicare trustees' report and recent technical revisions to the trustees' projections.

Then after Mr. Foster, we have Tricia Neuman, vice president of the Kaiser Family Foundation. Dr. Neuman will discuss the various drug benefit proposals that have been advanced in the Senate.

I think, Mr. Foster, we will start with you, then go to Dr. Neuman.

STATEMENT OF RICK FOSTER, CHIEF ACTUARY, HEALTH CARE FINANCING ADMINISTRATION, BALTIMORE, MD

Mr. FOSTER. Chairman Grassley, Senator Baucus, other distinguished members of the committee, thank you for inviting me to testify today about the financial outlook for the Medicare program.

I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the Nation's second-largest social insurance program.

I will briefly mention the factors affecting projected Medicare expenditures and their growth, and the findings of the 2000 Medicare Technical Review Panel. My written testimony, as well as the Trustees' Reports themselves, contain additional detail.

Regarding the factors underlying expenditure growth for Medicare, as shown in the new Trustees' Reports, in the short range, as Dr. Crippen mentioned, legislation has major effects on growth rates for Medicare. That includes, of course, the Balanced Budget Act, the Balanced Budget Refinement Act, and also the Benefits Improvement and Protection Act of 2000.

Beyond the legislation, cost growth generally is attributable to increases in, let us say, the number of beneficiaries, increases in the utilization of services and the price per service, as well as changes in the intensity of services or the average complexity.

Collectively, these sources of increase, after the legislative effects that I mentioned have sort of worn off, are projected by the Office of the Actuary to be in the neighborhood of about 6 to 7 percent per year. That is faster than the growth in wages, for example, or gross domestic product.

In the long run, expenditure growth also depends very heavily, as is well known, on demographic factors. Those include not only the retirement of the baby boom that we have been talking about for many years now, but also the average age of beneficiaries.

As they grow older, on average, they move into higher utilization categories for Medicare expenditures. In addition, of course, we have the continuing growth and the average expenditures per beneficiary.

The Medicare Technical Review Panel recommended that, for this long-range growth in average expenditures, we increase the assumption, the assumed rate of growth, to that of per capita GDP, plus 1 percent. That is about 1 percent per year faster than the trustees had traditionally assumed.

The recommendation was based largely on an assumed continuing impact of improvements in medical technology. The impli-

cations are clear. Mr. Chairman, you yourself mentioned the new projection that Medicare costs overall, as a percentage of GDP, are projected to increase from 2.2 percent today to about 8.5 percent at the end of our 75-year projection period.

Regarding the Medicare Technical Review Panel, let me mention, just briefly, its background. It is desirable to have a periodic, independent review of the financial projections in the Trustees Reports.

The 2000 panel was convened a year ago by the Board of Trustees to review the assumptions and methods underlying the Medicare projections. It consisted of seven expert health actuaries and economists who were nominated by the prior public members of the Board of Trustees.

They issued the report in December of 2000, which some of you may have seen. It contained a total of 38 findings and recommendations, most of which were in the nature of modest refinements to the existing methods. In general, they found that the methods and assumptions were reasonable, with the key exception of the long-range growth assumption that we just mentioned.

Now, for the 2001 Trustees' Reports, we effectively adopted every one of these recommendations that we could within the time frame. But the time frame was short. The recommendations adopted included the long-range growth rate of GDP plus 1 percent, corresponding changes to the short-range growth assumptions, and a refinement to the estimated cost of fee-for-service beneficiaries who switch to Medicare+Choice in a year.

We also adopted the recommendations regarding presentation, to place greater emphasis on the combined costs of Medicare, and also on the implications of continuing rapid growth in Part B expenditures—implications for beneficiaries and for the Federal budget.

Now, of course they had a number of other recommendations which have not yet been adopted, but will be considered for future reports as time permits and as the state of health care research permits.

I would like to sum up by saying that, again, I thank you for this opportunity to testify. I pledge the Office of the Actuary's continuing assistance, with the efforts by the Congress and by the administration, to determine effective solutions to the remaining financial problems facing Medicare.

I would be happy to answer any questions.

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

The CHAIRMAN. Thank you, Mr. Foster.

We will wait for questions until after Dr. Neuman gets done.

STATEMENT OF TRICIA NEUMAN, Sc.D., VICE PRESIDENT, KAISER FAMILY FOUNDATION, WASHINGTON, DC

Dr. NEUMAN. Thank you, Mr. Chairman and members of the committee.

Medicare today is one of the Nation's most successful Federal programs, yet it faces many challenges in the future. From the beneficiary perspective, however, no problem is more pressing than the need to improve prescription drug coverage.

More than one-quarter of the Medicare population lacked drug coverage throughout 1998. An even larger share, about half, had a gap in drug coverage or no coverage at all.

Seniors living in rural areas, the oldest old, and the near poor, are particularly prone to being without insurance to help cover the cost of their medications.

Medicare beneficiaries today rely upon a patchwork of supplemental sources to help with their drug costs. But this coverage is eroding, resulting in too many seniors not filling needed prescriptions and paying high out-of-pocket costs.

Several approaches to providing prescription drug coverage for the Medicare population are now at the forefront of the national debate, reflecting a range of philosophical perspectives, but also noteworthy areas of common ground.

For the first time in many years, the leading proposals reflect substantial consensus on the need to help all Medicare beneficiaries who lack drug coverage, with additional protections for those with low-incomes and those with catastrophic expenses.

Many proposals would also include financial incentives to urge some level of continued employer-sponsored coverage, acknowledging the significant role that employers now play in financing drug benefits for retirees.

And, reflecting lessons learned from the ill-fated Medicare Catastrophic Coverage Act, virtually all of the current proposals would allow beneficiaries to participate on a voluntary basis and none would use a government-administered pricing system. Beyond these similarities, important policy issues and differences remain, with significant implications for coverage and costs.

Clearly, one of these policy issues is determining how best to reach beneficiaries who lack drug coverage. A critical factor in helping those without drug coverage is affordability. Most proposals include premium subsidies for the general Medicare population, and they vary from 25 to 55 percent.

Decisions regarding premium subsidies will have a significant impact on participation, program spending, and the potential for selection problems.

Another challenge is developing a structure that helps seniors in all parts of the country, including rural and other difficult-to-serve areas. Some would address this concern by covering prescription drugs under traditional Medicare, as well as Medicare+Choice plans.

Others would subsidize private plans that offered drug benefits and give the Secretary authority to provide a fall-back in areas where private plans are not available.

Participation is also influenced by how easy the system is to negotiate. The easier it is for beneficiaries to sign up, pay their monthly premiums and stay covered, the more likely they are to do so.

Another critical set of policy decisions concerns benefits, including whether there should be a defined, uniform benefit or a benefit valued at a specific dollar amount.

With a defined benefit, each decision concerning deductibles, benefit levels, cost sharing, and catastrophic protection will directly impact the number of people who get help, the level of help they get, and program spending.

A specific dollar amount approach would avoid these types of decisions and give plans greater flexibility to adapt their benefit package. It could also limit the government's liability for drugs.

But this approach could also shift a greater share of cost to beneficiaries over time and create selection problems if plans modify their benefit packages to attract healthier and lower-cost enrollees. Variations in benefit packages could also be confusing for seniors.

Cost controls are another major challenge. Many proposals would delegate cost control decisions to private entities such as managed care plans or pharmacy benefit managers.

The success of these private plans in controlling costs, however, will depend on the authority they are given to implement the tools they use in the private sector, raising potentially difficult trade-offs between access and spending.

Another factor potentially affecting costs concerns the extent to which the government or private plans would bear risk for a new benefit. This decision also has implications for the willingness of private entities to enter and stay in the market.

Finally, how the new benefit is administered is another issue that cuts across plans, one that is often linked to broader discussions of reform. In considering these challenges, efforts to improve drug coverage must recognize the significant needs of the Medicare population: nearly 1 in 3 beneficiaries is in fair or poor health; about 1 in 4 have mental difficulties; 4 in 10 live on an income of less than about $17,000 for an individual.

Without a drug benefit, seniors today pay, on average, 20 percent of their income for health care. There is now an historic window of opportunity to address this problem with widespread agreement on the need to improve drug coverage, apparent bipartisan interest in arriving at a solution and public support for action. There is also a large Federal surplus that would greatly facilitate the financing of what promises to be an expensive addition to the Medicare program.

The decision about how much money to dedicate to a new drug benefit as opposed to other national priorities will be critical for determining whether the goal of providing meaningful prescription drug coverage for millions of older and disabled Americans can be realized.

Thank you.

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

The CHAIRMAN. Thank you very much.

I am going to start my questioning with Mr. Foster. We had the benefit of good economic growth, low health care costs, inflation, and the impact of the Balanced Budget Act of 1997 that have slowed the costs. Now we are being hit with predictions of 10-percent-a-year increases.

Could you give us an idea of how changes in the economy, or this medical inflation, or the Medicare spending might affect the trustees' estimates for Part A solvency in future years? Could you also provide some sort of example to help illustrate potential types of changes in these factors and the magnitude of the impact of Part A solvency?

Mr. FOSTER. Yes, sir. I would be happy to.

You are correct in noting that the financial position of Medicare generally, and especially Part A, is sensitive to how the economy does, as well as to growth rates in health care costs.

The trustees used three different sets of assumptions in order to illustrate the uncertainty and the potential variability due to changes in factors. As you know, under the trustees' intermediate set of assumptions, the Part A trust fund is projected to have its assets exhausted in 2029. That assumes moderate, not spectacular, economic growth, and similarly, middle-of-the-road medical-specific assumptions.

Now, on the other hand, if the economy slows down, if we have a recession or two in the next 10 years, if health costs simultaneously increase somewhat beyond the intermediate assumptions, then under the so-called high-cost assumptions, the Part A trust fund would go broke in 2016 rather than 2029.

On the other hand, if the economy continues to boom along nicely and health cost growth is modest, then the assets would never be depleted within the 75-year projection period. So the asset projection itself, as you can see, is very sensitive.

I would note, since you asked about which factors had more of an impact, that if you consider something like wage growth, if wages increase faster than we expect, then that carries through to higher payroll tax income, as you might imagine, because it is a tax on the wages. That is a 100-percent effect. If wages go up so much, taxes will go up so much.

On the other hand, Medicare expenditures would also increase with higher wages, but not by the full amount, because costs are partly wage-related and partly related to other things.

So if we have faster economic growth and faster real wage growth, you get both higher costs and higher income, but the income increase outweighs the higher cost, so it is favorable.

On the other hand, if you have faster growth in medical expenditures, that does not help us with the income. That merely means greater expenditures. That is a very pronounced effect.

The CHAIRMAN. I want to go to page 10 of your testimony, chart 7, and ask you to explain for us in a narrative way the trends shown in that chart. Could you tell us the consequences for our government and our economy in failing to act on that trend?

Mr. FOSTER. I would be glad to. At least, the first part will be easy. The second part, I am not so sure about.

In that chart, what we tried to do is show the combined Part A and Part B expenditure projection as a percentage of GDP. We show it both historically since the beginning of Medicare, and then for the next 75 years. That is the same 2.2 percent currently going to about 8.5 percent at the end of the period that we have talked about.

Now, we compare that to the currently scheduled sources of income for Medicare overall. We leave out interest income, because interest is not a major source of financing for Medicare in the long run. But we include payroll taxes, income taxes on Social Security benefits—we get a portion of those—the premiums paid by beneficiaries, and the general revenues specified for Part B.

The sum of those, as you can see in the chart, is not adequate to cover the total projected expenditures. The difference between

them is the same difference we have already seen and talked about for Part A of Medicare. So the difference we see here is attributable to the deficits we project for Part A.

It is interesting to note that under present law, if nothing is done, over time the beneficiary premiums and the general revenues keep pace with Part B expenditures, whereas the payroll tax income for Part A does not keep pace, so that, over time, the premiums and general revenues would come to represent a greater share of the total under present law.

The CHAIRMAN. All right. Since the yellow light is on, I will go to you.

Senator BAUCUS. Thank you very much, both of you.

You present lots of good options, lots of good considerations, both of you, and the prior panel as well.

Since I represent a thinly populated State and a rather poor State, I might say, regrettably, I might ask you, Dr. Neuman, among all the various different proposals you have heard about and heard discussed, and Senator Grassley clearly comes from a State that has rural beneficiaries as well, how do we take these various plans and tailor them to have a fall-back that really works, that provides fee-for-service coverage?

Particularly, I must say, in my State, it is really bad. Our people pay more than other rural beneficiaries because we are just so spread out in Montana, the distances are just so great. We pay, I think, virtually more than anybody else in the world, that is, uncovered beneficiaries.

We are, on a per capita basis on wage income, 50th in the Nation. We are 51st in the Nation, including Washington, DC, in disposable per capita income. We are 47th in the Nation in earned and unearned per capita income. We do not have any money.

These are people who are older people. Their families do not have a lot of money either, by definition, as I have just explained to you. So what do we do? How do I sit here and advocate something that protects, maybe not totally, but adequately, those people?

Dr. NEUMAN. I think this is one of the toughest issues, because what you are talking about is getting a benefit to people no matter where they live or what the service delivery system is. That is clearly a big challenge in rural areas.

All of the proposals that have been introduced would use private plans in one way or another to deliver benefits and manage costs. Some would have traditional Medicare contracts with private plans called pharmacy benefit managers.

That approach really would not depend on the delivery system. It could work wherever claims could be processed. So that is certainly one sort of relatively short bet.

It is possible, though, that other types of private plans may choose to come into rural areas. It would just depend on factors like the level of risk they would be required to take.

You have seen, from the experience of the Medicare+Choice program, that many private plans have been reluctant to go into rural areas.

Senator BAUCUS. Very. We had one for a while, and they pulled out. We do not have any.

Dr. NEUMAN. Yes. So you might want to think about a combination that would really assure people in rural areas that there is a stable and reliable back-up plan that could be defined.

Senator BAUCUS. Right. So how do we do that? How do we design it?

Dr. NEUMAN. One approach is to at least offer it as a fall-back through traditional Medicare and manage it through private plans. So it is still a public/private partnership, but it is available to people and would not require managed care plans to set up in rural areas if they do not find that to be an attractive alternative for them to pursue. As with doctor services today, the only sure bet for covering seniors in rural areas is to cover prescription drugs under traditional Medicare.

Senator BAUCUS. Another question is, other than a direct subsidy to employers, what other ways are there that we can induce firms to continue offering retiree health coverage, including prescription drugs?

Dr. NEUMAN. Well, there have been reinsurance options that have been put on the table that will pay for relatively high-cost beneficiaries who continue to be covered by their employer plan.

I think employers have said, according to work for the Foundation by Hewitt Associates, reinsurance arrangement or subsidies offered through employers would help slow the erosion of employer-based coverage, because, clearly, without that, what you do see is a decline of benefits offered to retirees.

Senator BAUCUS. Well, I appreciate it. You have worked very hard, both of you, in trying to help guide us here. These are not easy problems. Like someone once said—I think it was Senator Rockefeller—the more you get into it, the more complicated it becomes.

Sometimes it gets to the point where it is so complicated, and for seniors particularly complicated, that I think sometimes we are kind of off on the wrong track here by trying to just Band-Aid all these different pieces together.

We are forgetting the need to think seriously about something that is a lot different so that beneficiaries, the American people, feel a little more secure and at least know what they are getting.

It may not be everything they want, but they know what it is, without going through an awful lot of red tape paperwork and trying to figure out which choice, which plan to take, and not really knowing how to decide anyway, in most cases. But that is for another day. But thanks, in the interim, very much.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

I have a couple of questions that arise from the proposal that President Bush has submitted. His proposal is for $153 billion for prescription drug coverage over the next 10 years. He includes $11.2 billion as the first year benefit, 2002.

Assume that that is enough money to cover a drug benefit for low-income Medicare beneficiaries in the year 2002. If that amount is then adjusted each year for the 10-year period by the CBO new baseline growth for prescription drugs when you add up the 10 years you come to a total of $201.5 billion.

How would you recommend we adjust the projected cost of $201.5 billion down to the $153 billion, and once you have made that adjustment, what kind of prescription drug benefit do you have?

Mr. FOSTER. I would be happy to take the first whack at that.

Dr. NEUMAN. By all means.

Mr. FOSTER. The Bush Administration has only provided specifics so far for the immediate helping hand. This is a reasonably comprehensive drug benefit targeted to low-income people only.

The Office of the Actuary estimated the cost of that proposal, and that is the $48 billion that you hear about. It is intended to be temporary, over, say, a 4-year period, roughly.

It is quite a different issue to consider what you would do by way of adding a drug benefit for all Medicare beneficiaries, not just the low-income.

I believe Dr. Crippen noted that, if you tried to give all Medicare beneficiaries a benefit, for the amount of money that is referred to in the budget, it would be a "thin benefit."

If you targeted that amount of money toward subgroups of the Medicare population you could do something more comprehensive, but there have been no specifics on that so far.

Does that help at all?

Senator GRAHAM. Well, even with what we do know, if we assume that it is going to target low-income, and if we make the assumption that the first-year expenditure of $11.2 billion is the right number for that limited group of Medicare beneficiaries, if you just do the math of CBO's baseline growth in prescription drug cost for each of the next 9 years and add up the total, you come to $201.5 billion.

So, there must be some adjustment, even with a plan that is only targeted at the low-income Medicare beneficiaries. There must be something further being proposed to reduce the costs by approximately 25 percent below what it appears the cost would be.

Mr. FOSTER. I agree with you on the apparent disparity. I also look forward to working with the administration to find out exactly how to address it.

Senator GRAHAM. Dr. Neuman?

Dr. NEUMAN. I think the point that Mr. Crippen also made when he looked at it is that it would be about $200 billion to cover the near-poor. So I think the calculations that you have made and what he said would suggest that, really, the $153 billion may not be sufficient to cover the poor and near-poor, and clearly would not be sufficient to provide a universal drug benefit unless there were extremely limited benefits and very stringent cost controls.

Senator GRAHAM. A second question about the Bush proposal. As you know, the President takes the approximately $400 billion of estimated Medicare surplus over the 10 years and places it into a contingency fund. Then it is out of that contingency fund that things like a prescription drug benefit are to be financed.

The inference there is that the prescription drug benefit is going to be paid from Part A of Medicare rather than Part B of Medicare. What are the implications to the Part A trust fund and to health care issues of financing prescription drugs out of Part A?

Mr. FOSTER. This issue received a lot of attention at Tuesday's historic hearing, as I am sure you are aware.

Let me try to clarify that there is present law, and then there are proposals. Under present law, if a dollar of taxes goes into the Part A trust fund and it is a dollar we do not need right away, we will lend it to the Treasury Department to use as they see fit. But we will eventually get it back with interest. Under present law, we can only use it for Part A services. That is present law.

Under proposals, of course, anything can happen. We do not have specifics yet from the administration on what they have in mind. If, in fact, what they had in mind—and this is pure speculation—was paying for a drug benefit from the Part A trust fund without additional financing to cover the additional cost, then of course there would be significant implications for the solvency of the trust fund. I would be happy to provide for the record what the specific amount if it were $150 billion, would do.

Senator GRAHAM. I would be interested in getting that analysis. Also, would you analyze it at $201.5 billion, if that is the cost of the prescription drug benefit to be paid out of the Part A trust fund?

Mr. FOSTER. If we paid for all of the drug expenditures for Medicare beneficiaries out of Part A at a cost of $1.5 trillion, I can tell you what the implications would be pretty quickly.

[The following information was subsequently received for the record:]

A proposal to add a prescription drug benefit to Part A of Medicare, with an expected cost of $150–$200 billion over the first 10 years and without any additional financing for the trust fund, would obviously have a substantial impact on the fund's projected financial status. The specific impact would depend on the particulars of the proposal. In general, however, additional costs of this magnitude would advance the estimated year of asset exhaustion from 2029 (under present law) to about 2021 to 2023. In the long range, such a proposal would increase the 75-year actuarial deficit from the current estimate of 1.97 percent of taxable payroll to about 2.60 to 2.80 percent.

It is important to note that many Medicare drug proposals would cost substantially more than $150–$299 billion over the first 10 years. Such proposals, if applied to Part A and not financed through additional revenues or offsetting expenditure savings, would have a correspondingly greater impact on the year of exhaustion and actuarial deficit.

Senator GRAHAM. Dr. Neuman?

Dr. NEUMAN. I have nothing to add.

Senator GRAHAM. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Graham.

I have one question for Dr. Neuman and one question for Mr. Foster. Then I think we will be done. Let me remind you as well, that we may have questions that would be submitted to you in writing. We would appreciate a response in about two weeks.

One of your charts emphasizes that 78 percent of Medicare beneficiaries enrolled in Medicare HMOs have prescription drug coverage, and some coverage is even unlimited. That is a very encouraging number. Probably 100 percent of HMO people would have Medicare if we actually mandated a prescription drug benefit.

Clearly, we know that providing prescription drug coverage as part of an integrated set of benefits is in the best interests of beneficiaries. And while Medicare HMO markets have their limitations, as both Senator Baucus and I have pointed out, beneficiaries are served well in those areas that do offer Medicare HMO coverage, as is noted by the high beneficiary satisfaction rates.

With that in mind, how could Congress maximize the success of Medicare HMO markets in conjunction with a prescription drug benefit?

Dr. NEUMAN. Well, really, one thing that Congress could do is level the playing field, which might make it easier for HMOs, by offering a drug benefit through traditional Medicare.

It really creates a level playing field for both HMOs and the traditional program so that beneficiaries do not choose to go into HMOs if they happen to be able to afford to offer a drug benefit.

This would really create fairness for beneficiaries. It would also probably make it easier for plans, because that would be built into the cost, their payments. So that is certainly one thing that could be done.

I guess a second issue is to really think about the level of risk that plans are asked to bear. A goal would be to make sure that plans feel that they can come into a market, stay in a market, and be a reliable source of drug coverage.

In the past, they have expressed some reluctance to take on the full risk of a prescription drug benefit, so probably some thinking about risk sharing would be important to attract plans into a variety of markets around the country.

The CHAIRMAN. Thank you.

Mr. Foster, as you would recall from the Balanced Budget Act of 1997, it required that home health care expenses be transferred from the A trust fund to the B. The trustees report that the transfer of home health expenditures from A to B actually contributed to the short-term improvement of Part A trust funds. It is quite obvious, even without their reporting it, that that would have been the case.

Could you identify what portion of Part A surpluses are a result of that specific transfer?

Mr. FOSTER. We can do that. I do not have a figure for you right now, but I would be happy to provide it for the record.

[The following information was subsequently received for the record:]

We currently estimate that during calendar years 1998 through 2007—the first 10 years of the home health transfer under the Balanced Budget Act—the assets of the Part A trust fund will increase by a total of $364 billion. Excluding interest income, the corresponding surplus of tax revenues over expenditures is estimated to be $198 billion. These amounts are based on actual experience in 1998–2000 and the Trustees Report estimates for 2001 and later.

Over the same period, we estimate that a total of $100 billion in home health expenditures will be made from the Part B trust fund—rather than from Part A, as would have occurred in the absence of the Balanced Budget Act provision. Thus, without the home health transfer, the non-interest surplus would be about one-half (51 percent) of the current projection.

For the budget period of fiscal years 2002 through 2011, the absence of the home health transfer would reduce the non-interest Part A surplus by an estimated 57 percent.

Another way to assess the magnitude of the home health transfer is to consider its impact relative to the other legislative and non-legislative factors that, collectively, caused the change from a series of large Part A deficits to the current large surpluses. The 1997 Trustees Report projected a total non-interest deficit of $643 billion in 1998 through 2007. Thus, the total change in expenditures and/or tax revenues required to reach the current surpluses was $841 billion: $643 billion to eliminate the original deficits and another $198 billion to achieve the surpluses. The $100 billion in home health transfers represents 12 percent of the total change that occurred.

The CHAIRMAN. All right.

What if we continued this facade that Medicare is financially healthy due to the Part A surpluses? Is it not true that all we have to do is transfer more expenditures from A to B, and is this a fiscally responsible way of ensuring Medicare's financial health for the short and long term, and what are the consequences if more of that were done?

Mr. FOSTER. That, clearly, is a highly criticized provision in the Balanced Budget Act. If we go back a few years to when the legislation passed, we have to sort of reacclimate our thinking. The Part A trust fund was on the verge of going broke. Significant steps, hard-hitting steps, were necessary. In fact, most of the Balanced Budget Act was very hard-hitting.

Was it the right thing to do? Was it irresponsible? The Office of the Actuary not really get into policy issues. Clearly, all it was was shifting a significant part of one trust fund cost to another trust fund, which was equivalent to saying, "let us finance this benefit a different way."

I, myself, would have preferred a direct discussion of that issue rather than sort of what appeared to be sleight-of-hand and funny business. But things are not always as straightforward as we would like.

I will say that there was sort of a standing joke at the time that we should not have transferred home health, we should have transferred inpatient hospital care. Then we would have been all right.

So the legitimate part of it is, you can have a discussion on how to finance Medicare, how much should be payroll taxes, how much should be premiums, how much should be general revenues. Do you want to advance fund and get some interest income? Do you want to do other approaches? That is a perfectly legitimate discussion.

But to sort of look the other way and just transfer major expenditure categories, from my humble point of view, is not the best way to proceed.

The CHAIRMAN. Thank you.

Senator Graham, do you have another question?

Senator GRAHAM. I just have one question.

The CHAIRMAN. Would you please adjourn the meeting?

Senator GRAHAM. Sure.

The CHAIRMAN. The reason I ask you to do that is that I have a 5:00 meeting in my office. If you would do that, I would appreciate it very much.

Senator GRAHAM. For everybody's benefit, I have a 5:10 one, so this will be my last question.

The CHAIRMAN. All right.

Could I thank the participants, as I did the first panel, because obviously this is, in most people's minds, the most important thing we will be working on this year, or second, or third, whatever the case might be.

You are involved in a very important part of our decisionmaking process on one of our most important issues, and I thank you very much as Chairman of the committee, and for the committee.

Thank you.

Senator GRAHAM. Dr. Neuman, when you were outlining some of the basic choices, part of that analysis was the choice of a defined

benefit prescription drug plan as opposed to a defined contribution plan.

I have been thinking about a variation on the defined benefit. That is, two or more defined benefit plans. The reason that I have been thinking of this is, looking at the percentage of Medicare beneficiaries who already have some form of prescription drug coverage, about 60 percent of the Medicare beneficiaries, either through a previous employment relationship, through the purchase of Medigap insurance, through an HMO, or through Medicaid, have got some kind of assistance with their prescription drugs.

Of those four, my question is probably most relevant to the first group. That is the some 40 percent who get some assistance through a previous employment relationship.

Those people typically have some assistance in paying for their immediate prescription drugs. What they typically do not have is any kind of catastrophic coverage in case they get very sick and their costs become extremely expensive.

So they might decide that what they need is not a full-blown policy but, essentially, a policy against exorbitant costs. They can cover, through their existing employer-based policy, their expenses today.

Conversely, people who have no coverage at all are going to need that catastrophic in case they get very sick, but they also are going to want to have some coverage between zero and the catastrophic rate.

What are some of the implications of offering more than one defined benefit plan, and then allowing the Medicare beneficiaries to elect which of those plans best fits their circumstances, assuming that, for instance, the catastrophic-only plan would be attractive because it would have a lower monthly premium, since the amount of risk and costs to Medicare would be lessened?

Dr. NEUMAN. To make matters a little confusing and probably not as simple as you would prefer, I would say, that I can see one major advantage and one potential disadvantage that maybe Rick would want to comment about a little bit more.

The major advantage is that it would give seniors more choice to pick a package that better suits whatever their particular needs are. As you pointed out, people do have different levels of coverage, and that could be very, very attractive to people because they could buy what they want and not have to get a benefit package that they do not want.

The major consideration would be whether the different benefit packages result in a selection problem, because you would not want to be in a situation where sicker and higher-cost people are attracted to one benefit package and healthier people go into the other benefit package, because that could create selection problems and drive up the costs for one of the options, but not the other. But from a beneficiary point of view, it would seem to be a very attractive option.

Mr. FOSTER. You said that very well. I have nothing to add.

Senator GRAHAM. Thank you very much.

The meeting is adjourned.

[Whereupon, at 5:00 p.m., the hearing was recessed.]

FINDING THE RIGHT FIT: MEDICARE, PRESCRIPTION DRUGS AND CURRENT COVERAGE OPTIONS

TUESDAY, APRIL 24, 2001

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

The hearing was convened, pursuant to notice, at 10:03 a.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Snowe, Kyl, Baucus, Rockefeller, Breaux, Conrad, Graham, and Lincoln.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. I thank everybody for being here. The hearing will come to order. Today, the Finance Committee looks at this year's biggest issue or at least one of this year's biggest issues: Medicare reform and prescription drugs.

We do this for the second time because in the month of March, we heard testimony from a number of expert witnesses, including the Congressional Budget Office and the General Accounting Office regarding the potential cost of a Medicare drug benefit. This morning, we move forward to discuss the implications a new Medicare drug benefit may have on prescription drug options and also the extent to which prescription drug options are already available to older Americans.

Although Medicare does not provide a complete prescription drug benefit, it is incorrect to assume that the Medicare population is completely without any coverage. In fact, in 1998, 73 percent of Medicare beneficiaries had prescription drug coverage for some potion of the year. While some coverage may be limited, other coverage is much more comprehensive.

I have heard from Iowans on both sides of the coin; some need additional assistance for prescription drug costs. However, many others are terrified at the prospects of losing their current coverage as a result of any new Federal involvement in this area.

Today, the most common source of prescription drug coverage for the Medicare population is through employer-sponsored health plans for retirees. In fact, of all Medicare beneficiaries that have drug coverage, close to 45 percent have such coverage through employer-sponsored retiree plans.

Through these retiree plans, beneficiaries pay as little as $5 for generic drugs, $10 to $14 for brand-name pharmaceuticals. They experience modest deductibles and generally have no limit on annual drug expenditures. It is easy to understand then why older Americans want to maintain this kind of coverage, and it is very important for Congress to consider these facts as we craft Medicare legislation.

In addition to retiree health plan options, nearly 6 million Medicare beneficiaries receive prescription drug benefits through Medicare+Choice plans. Under these plans, beneficiaries enjoy the benefits of a coordinated approach to wellness and treatment.

Benefits such as disease management, step therapy, or home delivery are just a few of the additional pharmaceutical benefits available through a managed care approach. Still, other beneficiaries have access to prescription drug benefits through "Medigap" plans, Medicaid programs, and State Pharmacy Assistance Programs.

In light of these issues, Congress would be foolhardy to ignore coverage options now available to Medicare beneficiaries. There is no doubt a benefit guided by the Federal Government will impact current programs. However, the extent to which a new drug benefit can complement rather than supplant current coverage will result in a wiser use of the taxpayer's money and equally important, assurances that older Americans can keep the existing drug benefits that they really like.

This morning, we will hear from a panel of expert witnesses who will provide valuable information about the prescription drug options that are currently available to the Medicare population. In addition to learning more about these current options, I look forward to deepening my understanding of the lessons being learned by various States, Medicare risk plans, and employers in serving the diverse characteristics of the Medicare population. Their wisdom can be helpful to us as we consider how best to meet the needs of beneficiaries.

It is my hope that today's testimony will aid the Senate in creating a fiscally-responsible, common-sense Medicare drug benefit that includes much needed reforms of the program. I look forward to continuing to work on this critical issue with the assistance of each member of my committee.

And one person that will be very much involved in that is Senator Baucus, our ranking member.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you very much, Mr. Chairman. First of all, I appreciate you holding this hearing today. It is very important to people, particularly in rural parts of America who particularly lack prescription drug coverage. And I am hopeful that we will be able to provide some legislation this year that will offer benefits of those people.

I also remember what happened in the Senate three weeks ago during the debate about the budget resolution. All 100 Senators and the Vice President voted to provide up to $300 billion to fund a new prescription drug benefit. That was one of the major votes

that proceeded on the Senate floor during debate on the budget resolution. And I think that with this kind of broad bipartisan support behind us, we can move very quickly by focusing on the details.

Today, we are going to focus on the issue of those Medicare beneficiaries who already have some drug coverage. This coverage comes in many forms: employer-sponsored retiree plans, Medicare HMOs, Medicaid, Medigap, and State-based programs.

It is great that these people do have coverage even though in many cases the coverage is, I think, deficient. I am particularly concerned about the lack of prescription drug coverage in rural areas. I have said this many times. I will say it many times again. I will keep saying it until we finally correct the problem.

Rural seniors are 50 percent less likely to have drug coverage compared to urban seniors. Let me reiterate. Rural seniors are 50 percent less likely to have drug coverage compared to urban seniors. There are several reasons for this.

My State probably provides one of the best examples. Most seniors with drug coverage can get it through employer-sponsored retiree health plans. These plans usually offer the most comprehensive coverage.

But this coverage is rare in rural areas like Montana. Montana has fewer large employers who are more likely to offer retiree coverage. And in fact, Montana ranks last in the Nation with only 40 percent of firms offering health insurance for current workers.

Rural areas have very few Medicare HMOs. About two-thirds of seniors have access to a Medicare HMO, many of which offer drug coverage. Until last year, an HMO provided drugs for 2,600 seniors in the Billings, Montana area. But that plan, the only Medicare HMO in Montana, is now gone.

Very few Montana seniors have Medigap drug coverage. With an average premium of over $125 per month, Medigap is just too expensive for many Montanans. And even if they could afford it, this coverage is not very generous. It provides low benefit caps.

And what about Medicaid? Although Montana seniors are not usually wealthy, Medicaid covers only the very poor, about 13,600 Montana seniors. For the vast majority of Montana's 138,000 Medicare beneficiaries, Medicaid therefore is not an option.

Finally, 26 States have, or will soon implement, pharmacy assistance programs, leaving 24 that do not. Montana does not have such a program. And I do not anticipate that we in Montana will adopt such a program soon. We cannot afford it. At least, that is the opinion of the legislature. Severe budget troubles and a legislature that meets only biannually make this a very unlikely option for Montana seniors in the near term.

So the needs are great, especially from my perspective in rural America. That means that we have a tremendous opportunity to make a difference. And I hope we do so. We certainly have an obligation.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Baucus.

Now, I will introduce our panel and thank them for not only the time it takes for preparation for a hearing like this, but also those who had to come a distance to do it. Thank you very much.

Steven M. Coppock, principal, Hewitt Associates, Rowayton, Connecticut; Karen Ignagni, president and chief executive officer of the American Association of Health Plans; Dr. Deborah J. Chollet, senior fellow, Mathematica Policy Research here in Washington, DC; Dr. Raymond C. Scheppach, executive director, National Governors Association; and Dr. Stephen Crystal, a research professor, chair of the division on aging, Associate Director for Research, Center for State Health Policy, Institute for Health, Health Care Policy, and Aging Research, Rutgers University, New Brunswick, NJ.

And, Dr. Crystal, if Senator Torricelli came, he had asked to introduce you. So I will let him repeat all of that. [Laughter.]

For all of you, we have the 5-minute limit. But I wanted to make sure, without abusing anybody's time, that you ought to at least feel free to finish your main thought before you stop even if the red light is on, but do not go too much beyond that period of time.

Second, because all of you hopefully have longer testimony, that will all be included in the record without your asking that it be inncluded.

And lastly, for the members who are here as well as maybe some who have conflicts and cannot come, we would expect that you will ask some questions for answers in writing and that you would return those within two weeks. We will also say, for those of you who have not been through the process of answering in writing for a committee, we will be glad to have the staff of either Senator Baucus or my staff help you with that.

I am going to go in the order we introduced you. So we will first go with Mr. Coppock.

STATEMENT OF STEVEN M. COPPOCK, PRINCIPAL, HEWITT ASSOCIATES, LLC, ROWAYTON, CT

Mr. COPPOCK. Thank you, Mr. Chairman for the opportunity to testify on the current prescription drug environment for Medicare beneficiaries with employer-sponsored coverage and the implications of a new Medicare benefit on that environment.

My name is Steve Coppock and I am a Principal with Hewitt Associates which is a global management consultant and benefits delivery firm and the largest employee benefit consulting firm in the U.S. Hewitt primarily works with large employers that have 1,000 or more employees.

As Congress considers proposals to reform Medicare and to develop a prescription drug benefit for Medicare beneficiaries, this committee is to be commended for its efforts to understand the impact of these proposals on employer-sponsored retiree health coverage. My testimony will draw from a report Hewitt prepared in July of 2000 for the Henry J. Kaiser Family Foundation and on other Hewitt data and experiences.

First, I would like to make a few key points about the current status of employer-sponsored retiree health benefits. Employers are the largest source of prescription drug coverage for Medicare eligible beneficiaries covering 12.4 million individuals. That is nearly 45 percent of the 27.8 million Medicare beneficiaries with some form of prescription drug coverage and 33 percent of the total noninstitutionalized Medicare population.

Employer-sponsored retiree health insurance almost always offers more generous coverage than other private health insurance, such as providing unlimited drug benefits with no caps. Retirees in employer-sponsored plans receive more in drug benefits, 13 percent more than Medigap beneficiaries and 57 percent more than Medicare+Choice beneficiaries, and pay less out of pocket for every dollar spent on out-of-pocket charges in employer-sponsored plans.

Beneficiaries in Medigap plans spend $2. And beneficiaries in Medicare+Choice plans spend $1.37. Therefore, it is not surprising that retirees appreciate the value of their employer-sponsored benefits.

Retiree prescription drug benefits are typically part of the employer's overall retiree health coverage and do not have separate premiums. In the majority of cases, retiree drug benefits contain specific provisions for prescription drug coverage separate from the other medical expenses.

Retiree drug coverage usually requires flat-dollar co-payments per prescription, but increasingly employers are using three-tier copayment systems whereby lower co-payments are charged for generic or preferred brand-name drugs. Employers use several tools to control the utilization and cost of prescription drug programs, such as mail order benefits, disease management programs, and pharmacy benefit managers or PBMs to administer the drug benefit.

These tools are adopted in an effort to balance access, choice, quality, and affordability. Retiree drug expenditures have been growing at double-digit rates. And we are projecting a 15-percent annual trend from now until 2003.

Prescription drug benefits represent a significant portion, 40 to 60 percent, of the total cost of the retiree health care benefit. And we project that it will increase to 80 percent by 2003. We estimate that absent any changes in law and assuming the continuation of current coverage that employers will spend $22.5 billion in aggregate on prescription drug coverage for Medicare eligible retirees in 2003, growing to $37.1 billion by 2009.

The prevalence of retiree health coverage has declined in recent years with some employers dropping coverage and few newer employers adding retiree health coverage. Between 1991 and 2000, there was an 18-percentage point drop in the proportion of large employers offering retiree health coverage to Medicare eligible retirees.

Mr. Chairman, you asked for our views on what issues and options Congress should consider in coordinating a Medicare benefit with employer retiree drug coverage. It is hard to generalize about the effects of a Medicare drug benefit without knowing a great deal of specific information.

Obviously, the details matter enormously, but here are some general thoughts. It is probably in the common interest of Medicare, of retirees, and employers if some positive incentives were added to encourage employers to retain these programs. This is the group of employers who have continued to offer coverage even when others have not.

After accounting for proposed Medicare drug benefits, employers would still spend approximately 71 to 77 percent of their current

total per retiree cost in 2003 for Medicare eligible retiree health benefits when wrapping around a proposed Medicare drug benefit. And employer spending would be even higher if they pay all or part of any retiree premium required for the Medicare drug benefit.

Conversely, employer spending would be reduced if a $4,000 Federal stop-loss provision is added. But even then, employers would still be spending approximately 66 percent of their current total per retiree cost in 2003 for Medicare eligible retiree health benefits.

If a universal drug benefit were available to Medicare beneficiaries, employers would react differently, depending on its provisions and their circumstances at the time. But in surveys that we have, 85 percent of employers have said that they would remain involved in retiree drug coverage in some manner.

Coordination of coverage with Medicare is critically important for employers. In other words, the simpler the coordination possibilities, the better, all else being equal.

In conclusion, employers base their decisions regarding their retiree health programs on many factors besides a potential Medicare drug benefit. So the committee may wish to consider additional ways of encouraging employers to sponsor retiree health programs.

Thank you for this opportunity to present our findings.

The CHAIRMAN. Thank you, Mr. Coppock.

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

The CHAIRMAN. Now, Ms. Ignagni.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF HEALTH PLANS, WASHINGTON, DC

Ms. IGNAGNI. Thank you, Mr. Chairman. Good morning, members of the committee. I am Karen Ignagni, the President of the American Association of Health Plans. We appreciate very much the opportunity to testify this morning. We are testifying on behalf of the organizations providing coverage to 95 percent of working families, virtually all of Medicare+Choice beneficiaries, many of whom are the retirees in employer-based programs that Mr. Coppock just referred to.

As you know, choice plans have been an important source of health care coverage, particularly for those on fixed incomes. It has been a major source of prescription protection for those without other forms of coverage. And indeed, last year's MedPAC report illustrates that beneficiaries in choice spent $1,000 less out of pocket each year for benefits.

This hearing, in our view, marks an important milestone. It is very clear that given the instructions to all of us in preparing our testimony that the Congress has made the transition from whether to provide and to organize a prescription drug benefit to how to provide.

And in light of those instructions, we have taken two fundamental points into consideration as we have prepared our testimony. First, the complexity of the policy design questions before you, and specifically how to ensure when you are finished that it will work.

Second, the unequivocal evidence of the importance of prescription drugs for this population and the difficult job of ensuring the country can afford and sustain it.

With respect to the goal of designing a program that will work, we offer six principles for your consideration:

First, giving all beneficiaries access to the benefits with special provisions for low-income individuals;

Second, providing beneficiary choice plans, letting the market work for them, giving them options above whatever is done in the traditional program;

Third, flexibility in benefit design, encouraging innovative approaches to cost containment;

Fourth, funding sustainability;

Fifth, effective regulatory frameworks, giving beneficiaries the information they need, holding participants and plans accountable, but not micromanaging; and

Sixth, care coordination because it has become very clear to us since we are very much involved not only in providing drugs on the working family side, but also the Medicare+Choice that it is much more effective to provide integrated care rather than episodic care. And I will come back to that.

We hope that these principles will be useful to you as you proceed. At the same time, given our members' experience in providing prescription drugs, our plans recognize that to succeed, the prescription drug benefit must be affordable and sustainable.

To this end, plans have pioneered techniques and safeguard benefits while containing costs and ensuring quality. They do include some of the factors that Mr. Coppock just referred to. I would like to cover a few others.

I would like to mention formularies which have been designed to provide safe, effective, and affordable coverage. Within these programs, we have emphasized generic drugs. Within these programs, we have used several tiers of benefits, giving consumers various options and maximizing their choice.

We have also built in mail order features for those who have chronic conditions. Our disease management strategies, we have targeted chronic conditions with the highest prevalence.

We have also targeted diseases with the most variations and treatment. And we have also targeted diseases that carry the highest risk of ignoring and the importance of doing things very early. We have incorporated step therapy which basically means you begin as conservatively as you can and you progress to more complicated regiments.

Then, we have also relied on the scientific evidence. And the best example of that would be the usage of beta blockers. We have pioneered the usage of beta blockers post-heart attack to prevent people from having another heart attack. So we have been very focused on the usage of prescription drugs to prevent more catastrophes down the line.

And finally, we have learned the value of follow-up care to make sure that individuals are using their prescriptions the right way, they are receiving refills when they need to, and they understand the instructions.

In our testimony, we have also mentioned the regulatory framework. Our members have developed specific proposals with respect to other regulatory framework for Medicare broadly, as well as in the context of prescription drugs. And I would be happy to comment on that in questions, should you care to question more on that subject.

To conclude, our members have learned firsthand the value of choices to Medicare beneficiaries, particularly for those on fixed incomes. Since our plans wrestle every day with how to maintain access to prescription drugs, at a time of dramatic increases in expenditures, we hope that the Congress and this committee can draw upon our experience.

I want to thank you for the bipartisan efforts to save Medicare+Choice. We hope that the committee and Congress will continue with the job because of the importance of this benefit for many individuals around the country.

Medicare+Choice offers Congress a dual platform in our view. One is to continue giving beneficiaries choice or moving toward a broader discussion of reform. It works. It provides affordable benefits. And it has improved quality.

We hope that the Congress will take the steps necessary to provide the peace of mind that prescription drug coverage would bring to seniors. And we hope that our testimony contributes to the process of meeting that goal.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

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

STATEMENT OF DEBORAH J. CHOLLET, SENIOR FELLOW MATHEMATICA POLICY RESEARCH, INC., WASHINGTON, DC

Dr. CHOLLET. Senator Grassley and members of the committee, thank you for inviting me this morning to comment on the role of Medigap policies in providing Medicare beneficiaries coverage for prescription drugs.

I am an economist and a health services researcher at Mathematica Policy Research. However, none of my views should be construed as representing in any way a corporate opinion or a corporate view of Mathematica.

About one-fourth of Medicare beneficiaries hold Medigap coverage to supplement Medicare benefits. And about 40 percent of these appear to have at least some coverage for prescription drugs. That is, about 10 percent of Medicare beneficiaries overall appear to have some Medigap coverage for prescription drugs.

About three-fourths of Medigap policyholders with prescription drug coverage are in pre-standard plans. These plans were sold before July, 1992 when Medigap policies were standardized and have been renewed continuously since then.

Every Medicare beneficiary with pre-standard coverage is now at least 74 years old. Since 1992, fewer than 9 percent of Medicare beneficiaries who had bought a Medigap policy of any kind have bought a standard policy that covers prescription drugs. It is just 9 percent.

The Medigap market is heavily underwritten. Insurers are very selective about whom they sell coverage to. And under Federal law and in most States, insurers can deny coverage to any Medicare beneficiary after age 65.

Nevertheless, Medigap policies that cover prescription drugs are very expensive relative to any measure of the elderly's income and relative to standard Medigap policies that do not cover prescription drugs. Medigap policies that cover prescription drugs, that is the standard rate available to a male aged 65, run between $2,300 and $3,000 per year.

I believe that Medicare coverage for prescription drugs can have a very positive impact for Medigap policyholders and also on the Medigap market. Obviously, it would assist the 60 percent of Medigap policyholders who have no coverage at all for prescription drugs. These include 90 percent of all Medicare beneficiaries who have purchased Medigap coverage in the last 10 years.

However, it could also help to address at least three serious and growing problems in Medigap market. These are Medigap lock-in in the pre-standard plans, the very fast growth of premiums for Medigap policies that cover prescription drugs, and the failure of competition among Medigap insurers for prescription drug coverage.

Let me address each of these quickly. First, Medigap lock-in, three-fourths of Medigap policyholders with prescription drug coverage are in pre-standard plans. These plans offer very meager coverage for prescription drugs, but policyholders in pre-standard plans have no alternative source of coverage for prescription drugs, except the Medicare+Choice plan if one is available in their area.

If they enter a Medicare+Choice plan and wish to leave or if the plan withdraws from the market, these policyholders may not reenter their pre-standard policies. And they are not guaranteed issue into any standard policy that would cover prescription drugs. Lock-on for Medigap policyholders, especially in plans that offer prescription drugs, is a serious problem that is likely to worsen.

Second, the fast growth of Medigap premiums for prescription drug coverage. Medigap premiums for these plans are rising very fast. Between 1998 and 2000, the average standard premium for H coverage, this is the lowest coverage in the standard market that would cover prescription drugs, rose 49 percent.

The fast growth of premiums in these plans suggests that adverse selection may be a problem and that they are at risk of being closed. Many insurers are running only closed plans for prescription drugs. In this event, if these plans close, new Medicare beneficiaries may have no access at all to Medigap coverage for prescription drugs.

Finally, the failure of competition in the Medigap market. One reason for the fast growth of these premiums is the fact that the elderly in Medigap plans buy prescription drugs at full retail prices. As organized large buyers, such as the Federal Government and State Medicaid programs have negotiated discounts from the drug manufacturers, full retail prices have risen.

Other people who pay full retail prices, of course, are the elderly without any coverage at all for prescription drugs. But having coverage for prescription drugs from impassive insurers is not signifi-

cantly better than having no coverage at all with respect to the prices paid.

Various facts point to a failure of competition in the Medigap market. Prices for the same standard Medigap policy vary dramatically in the same geographic location.

Underwriting rules severely restrict policyholders from changing plans after they first buy a Medigap policy at age 65. In this market, insurers have little reason and no incentive to negotiate preferred prices for prescription drugs. And if they did, they would fear adverse selection.

In summary, Medicare coverage for prescription drugs might offer advantages to both policyholders and insurers in the Medigap market. It would cover most policyholders who now have no coverage for prescription drugs nor access to drug coverage after age 65, except through Medicare+Choice plans.

It would allow insurers to restructure Medigap policies to ensure more adequate supplemental coverage for all services, including prescription drugs. The Federal Government could negotiate lower prescription drugs for Medicare beneficiaries when Medigap insurers have no incentive or ability to do so. And finally, it could resolve the growing problem of Medigap lock-in, especially in Medigap polices that cover prescription drugs.

Thank you again for inviting me to comment on Medigap market and coverage. I would be pleased to assist the committee in any way as it continues to pursue these issues.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Now, Dr. Scheppach.

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS ASSOCIATION, WASHINGTON, DC

Dr. SCHEPPACH. Thank you, Mr. Chairman. From the Governor's standpoint, the major issue surrounding a Medicare drug benefit is its relationship to Medicaid. Since its enactment, Medicaid has changed. And expansions require coverage for many groups, including the elderly, up to 120 percent of poverty.

It now covers more Americans than Medicare or any other insurer. It funds care for 1 out of 8 Americans, 1 in 4 children, 40 percent of births in the entire country, and approximately one-half the nursing home care. In 1990, Medicaid covered a little bit less than 29 million people. It currently covers 41 billion, at a total cost exceeding $200 billion.

Medicaid expenditures for prescription drugs almost doubled in the years between 1993 and 1998, rising from $8 billion to almost $14 billion despite a reduction in case loading. The average cost has risen during that period from $333 to $699 over that same period. And drugs now cost 10 percent of the Medicaid program and are increasing about 18 percent per year.

In fact, Medicaid itself now probably gone back into the double-digit figures of around 12 percent. And given the reductions in State revenues, it is probably eating up at this time every additional revenue that States can generate.

Within the Medicaid program, it is clearly the dual eligibles that have the greatest concern. Approximately, 15 percent of Medicare beneficiaries are also eligible for Medicaid.

These dually eligible beneficiaries, however, account for 30 percent of all Medicare spending of about $62 billion in 1997. Dual eligibles also account for 35 percent of Medicaid expenditures or about $58 billion in 1997.

The majority of the 6 million dually eligible beneficiaries, about 5.4 million receive full Medicaid coverage. Medicaid coverage provides coverage for their Medicaid premium cost sharing expenses and for services not covered by Medicare, including long-term care and outpatient prescription drugs. The remaining 600,000 beneficiaries are not eligible for full Medicaid coverage, but do receive Medicaid assistance for Medicare premiums and other cost savings expenses.

In terms of some overall recommendations and lessons that we have learned from Medicaid, I would offer the following.

First, if a universal benefit is created within the Medicare program, it must be truly a Federal benefit. Although States have picked up an increasing share of this burden through Medicaid and State-only programs, these are band-aids and should not be viewed as an alternative to a comprehensive Medicare benefit.

Second, to the extent that full or partial subsidies for low-income individuals are created or enhanced, it is critical that they be federally financed. Otherwise, any benefit that relies on recipient cost sharing will simply be a cost shift to the Medicaid program.

Third, it is important that the Federal Government have the ability to negotiate prices on this. Clearly, I think that they have to develop alternative strategies where you have generics versus brand pharmaceuticals. Aggressive utilization review is extremely important when you run a particularly program. And it is critical that Medicare invest in an effective information system.

Because there is likely to be too little money to assist in providing all drugs for all beneficiaries, and there are legitimate concerns about subsidizing certain types of drugs, then some choices do need to be made about coverage which means formularies and other approaches.

Finally, if a voluntary benefit is created within the Medicare program, there must be a mechanism to allow the States to require enrollment for individuals dually eligible for Medicare and Medicaid. Dual eligibles currently have 100 percent of their out-of-pocket costs paid by the Medicaid program.

And there is no incentive for them to enroll in a voluntary drug benefit. This is also true for any aspect of the program that relies on physical incentives or market decisions to influence beneficiary behaviors.

I thank you, Mr. Chairman. And I would be happy to work with the committee.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. Now, Dr. Crystal.

STATEMENT OF STEPHEN CRYSTAL, RESEARCH PROFESSOR; CHAIR, DIVISION ON AGING; ASSOCIATE DIRECTOR FOR RESEARCH, CENTER FOR STATE HEALTH POLICY; INSTITUTE FOR HEALTH, HEALTH CARE POLICY, AND AGING RESEARCH, RUTGERS UNIVERSITY, NEW BRUNSWICK, NJ

Dr. CRYSTAL. Thank you very much. We estimate for programs operating throughout the year 2000, the State direct benefit programs, the enrollment was approximately 860,000. With some of the new programs opening and increases due to program expansions and also to the withdrawals of Medicare HMOs in some areas, the number may be up to around 1.1 million, but it is still a relatively small proportion of Medicare beneficiaries. We estimate less than 3 percent.

Nevertheless, those programs are extremely important to those who participate in them. They are typically targeted to individuals whose income is low, but above Medicaid eligibility levels. They are especially important since in those income ranges, out-of-pocket health care costs and particularly for pharmaceuticals are extremely burdensome.

In a recent study with national data, we estimated that health care expenditures accounted for 32 percent of people's income for those living in the lowest one-fifth of the income distribution, and 24 percent for those in the second lowest fifth. And in both quintals, prescription drug costs accounted for about 40 percent of out-of-pocket health care expenditures.

So for people in that income range, the protection is extremely important. As Dr. Scheppach said, these programs are far from constituting a national drug safety net or even a financially stable system because of their growing costs.

They constitute a spotty and uneven system in which protection depends on where you live. We are up to close to 25 States, but most of the enrollment is really only in a few States. Forty-nine percent of the enrollment, we estimate is just in two States, Pennsylvania and New Jersey, 72 in those two States, plus New York and Massachusetts.

There are six States where enrollments exceeded 10 percent of Medicare enrollment, but many of the programs are very limited. They are programs that are limited to people with particular conditions, programs that are limited to only certain drugs.

So these are certainly not a safety net system at present. And they are under a considerable amount of financial pressure.

The designs in terms of eligibility, cost sharing, and other program characteristics vary widely. Seven programs also include disabled residents who tend to cost more. The eligibility limits range from 100 percent of poverty to in some cases a partial benefit for those at more than 400 percent of poverty, but most of the programs are in the range of about 150 percent to 260 percent of poverty.

What this means is that unless for the full benefit, the means tested portion of a Federal benefit if there is one unless it is quite generous, many of the States that do have programs would be more generous than the Federal benefits. So the issue would arise whether they can and will wrap around so as to supplement, to bring people up to the same level that they are at present.

Many of the people from the programs have said that they would like to do that, but they are concerned that the program design be one that makes it relatively simple and straightforward for that to happen. And they are concerned in the light of the kinds of experiences that they have with coordination of benefits in the existing system which is a difficult problem, that some type of coordination be built into them if they are going to be able and willing to sort of keep their dollars in pharmacy assistance.

If their dollars are freed up, there will be a great amount of competition obviously for other health care needs. So this was something that we heard quite a bit from people in the States about the need to build a coordination of benefits to build something into the system that would make it easy for them wrap around and perhaps give the States the option of administering a Federal benefit in States like Pennsylvania that have developed a very systematic system.

Finally, they are very concerned from their experience with beneficiaries about their ability to deal with the complexity, and if the market becomes more complex, their ability to deal with the beneficiaries have difficulty understanding their existing coverage and understanding even how the State programs work.

So they urge that the benefits of simplicity and comprehensibility be considered along with those of choice.

I would be happy to address any questions. Thank you.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. And you all need to be praised for finishing on time. I appreciate that very much.

We are going to have 5-minute turns for each member. And just sort of remember how the clerk established your coming in on the early bird roll. That would be and then Senator Baucus, Senator Hatch, Senator Kyl, Senator Breaux, Senator Rockefeller, and Senator Snowe.

Mr. Coppock, the data indicate that since 1993, the number of employers offering retiree medical benefits has dropped from 40 percent to 24 percent. And I want to explore with you the accuracy of that number and what factors may have been contributing to the decline.

So what factors might be contributing? And is it an increase in the aggregate number of employers overall? Maybe, it will result in a start-up of tech companies with much younger employee populations or some other combination of factors.

Mr. COPPOCK. Mr. Chairman, I believe it is a combination of factors, a couple that are related to cost and then one that does not necessarily relate to cost. And then, I will comment on the accuracy of the proportion of employers.

The two that relate to cost, I mentioned in my testimony that prescription drug expenditures are clearly going up much faster than other health-related expenditures. We estimate about 15 percent for the next two or 3 years. So prescription drug coverage and the costs associated with that has clearly gotten the attention of employers with respect to retiree health care.

So in terms of try to manage the overall cost of running business for these large and small and medium employers, that is an area

that has gotten an intense amount of scrutiny. And for some large employers and small employers in greater proportions, those benefits have fallen by the wayside.

The second factor related to cost has to do with the accounting standards phase 106 accounting standards that were put in place in 1993 when large employers adopted those provisions. Essentially, I will not go into the accounting rules, but for every $1 impact in the current year on health-related benefits for these employers' retiree benefits, there can be as much as 6 to 10 times factor related to their accounting cost that they have to incur on their profit and loss statements.

So a 15-percent change in the current year will have a dramatic impact on their accounting costs that phase 106 asked them to incur for their profit and loss statement.

The third factor that does not have to do with cost, and you alluded to this in your question, has to do with the changing work force issues, whether it is high-tech companies or other organizations that are not high-tech companies feeling the pressures of a very mobile work force and the fact that many employees who they hire never actually make it their retirement eligibility provisions.

So to the extent that you are going to try to attract and retain and motivate people for a shorter period of time, retiree health benefits becomes less of a motivator, less an attractor, less an engagement factor for the employees that the organizations are trying to bring into their company to compete in the marketplace.

With respect to the accuracy of the data, I just alluded to a few things. I think it is a mix of some of the larger employers who have dropped retiree health coverage, although I think that is probably the minority proportion relative to the data you are looking.

And then also, newer organizations, call them high tech, call them whatever you want, who because of competitive reasons have chosen not to offer retiree health care coverage as they have either started or their businesses have grown.

The CHAIRMAN. Ms. Ignagni, I want you to elaborate in your testimony where you noted that care coordination techniques of Medicare+Choice plans, like disease management programs, drug formularies, as well as pharmacy management programs, allow plans to treat patients more effectively and lead to significant savings.

Ms. IGNAGNI. Yes, sir. I would appreciate the opportunity to do so. Essentially, what our plans have done is pioneered an integrated approach to the treatment of chronic conditions. You can use asthma as an example, diabetes, congestive heart, pulmonary disease to do whatever is necessary as early as possible to prevent catastrophes later on.

We found that the existence of prescription drug therapies and availability is very key in the treatment of these diseases and the management of these diseases. A stunning statistic indicates that about 80 percent of seniors over 65 have at least one chronic condition. And now, 70 percent have at least two.

So that makes the point about the urgency of an integrated approach that looks at the entire person in treating disease. That allows you to intervene, on one hand, and achieve economies on the other.

So where you may be providing more by way of prescription drugs, you can prevent visits to the emergency room, prevent amputation in the case of diabetes, limbs lost, blindness, etcetera. So those are just a couple of examples.

The CHAIRMAN. Thank you.

Dr. Chollet, you made a pretty strong point about the high cost of Medigap policies offering prescription drug programs. Why are premiums and cost sharing of Medigap policies that offer drugs so high? And could you elaborate on what techniques insurers have used to respond to the rising cost and how beneficiaries have been hurt as a result?

Dr. CHOLLET. Yes. The coverage for prescription drugs in Medigap policies is standard. There is a deductible of $250. There is a 50-percent co-insurance rate. And there is a cap of either about $1,200 or $3,000 depending on the policy form, a cap of coverage in these policies.

The 50-percent cost sharing rate, the co-insurance rate mirrors the 50-percent co-insurance rate that was available commonly in policies that preceded standardization of Medigap policies. Therefore, we believe that for the three-quarters of Medigap policyholders that have prescription drug coverage, they also are looking at a 50-percent co-insurance rate. And if they are in the pre-standard ARP plan, a $500 annual cap on covered drugs.

So the coverage is meager. It is standardized, but the standardized portion of the market looks essentially like with higher caps what the pre-standard market looked like.

In this market, because Medigap policyholders cannot move easily from policy to policy, we find that many insurers are covering just a few lives in a State. A Medigap policyholder will move from the State in which they retired, where they first bought the Medigap policy. They will move to another State. And they will retain that Medigap policy.

So most insurers in this market have a wide diffusion of covered beneficiaries across State lines. In this kind of a market, it is very hard to get enough traction to negotiate with prescription drug coverage for preferred prices for a large share of your business unless you happen to have a very constituted block of business in one particular area.

And in addition, there is evidence that there is adverse selection in general in the Medigap and especially in Medigap plans, the pre-standard plans, H, I, and J, that cover prescription drugs. So an insurer that did negotiate for preferred prices for policyholders and sent up an advertising flag that they had negotiated these better prices, would set themselves up for adverse selection. They would be very unlikely to do so.

As a result, all the market incentives in effect prohibit insurers from being active in negotiating better prices for policyholders.

The CHAIRMAN. Thank you, Dr. Chollet.

Now, Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. I thank everybody for all that you are saying. It does help. But frankly, I hear that employer-provided plans are good for a lot of employees. Maybe, some are providing fewer benefits for the reasons that you have indicated.

Medicare HMOs do not operate in my State of Montana. Medigap is extremely expensive for what you get. Medicaid does not really help very much. Private insurers do not want to insure.

What do we do? I mean, I am speaking about my constituents. People I am talking about right now are people in rural parts of America. They just do not have prescription drug benefits. Now, some States have enacted some programs. And I suspect they will be somewhat helpful.

But what do we do for those people? It seems to me that the only thing we can do is enact a universal prescription drug benefit and then work with the crowding out problems that might occur with the employer provided retiree programs.

And I do not know what we will do with the HMOs. Medigap will I guess do whatever they can do. And Medicaid will still be around. And the private sector I guess still will not participate very much. At least, we have not heard of private insurers rushing in to provide these programs, for example under the House-passed Republican plan last year.

But who on the panel has an idea to help provide prescription drug benefits for people living in very rural remote areas? Does anyone want to take a crack at it?

Dr. CHOLLET. I just wanted to say that obviously the reason that we have Medicare is the failure of the market to ensure elders adequately. And therefore, I do not think that it should be surprising to any of us that when we have a major cost category that is not covered by Medicare that the market would not be highly successful in delivering that either.

So I think the answer here is Medicare coverage for a major cost category that is becoming increasingly important in modern medical practice.

Senator BAUCUS. So you are talking about universal benefit?

Dr. CHOLLET. Yes, sir.

Senator BAUCUS. All right. Ms. Ignagni.

Ms. IGNAGNI. Senator, I think that you can go forward in terms of offering a benefit to all Medicare beneficiaries and giving options. You have options out there in the market now absent the government providing any Medicare beneficiary any kind of coverage for prescription drugs.

So what I see is if you go forward with a benefit of some sort, then I think employers will wrap around that. I think Medicare+Choice to the extent you continue to preserve it will be available, will do better. And I think there will probably be other entities that will develop with other models to provide beneficiaries more.

So I think that is a platform for more opportunities, more choices, but I do not think it is about one size fits all.

In terms of the rural area, we have actually spent a great deal of time over the last few months consulting with a number of individuals in the rural communities, and have some thoughts about how to move forward with other alternatives in the rural area. I do not think you——

Senator BAUCUS. I hear you and I appreciate that. To be honest about it, rural beneficiaries are in many respects subsidizing urban beneficiaries because we are all paying the same premiums.

But a lot of HMOs provide some free drug coverage, free eyeglasses, free dental, free hearing that certainly are not provided for Medicare beneficiaries today. And the thought and concern is that a lot of the HMOs cream the most healthy off the top so that they can "be more efficient."

And it is a concern we have. And we are supposed to be one country. And it just seems to me that people in rural areas should not be disadvantaged when it comes to prescription drugs or Medicare compared to people in urban parts of the country.

I just urge all of us to think in ways to make sure that everybody is included here at the same rate and not discriminated against.

Ms. IGNAGNI. And it very well be, Senator, just to finish the thought about rural areas that there may be some special sorts of treatment. What we are finding in our discussions with a number of our plans that there are basically three problems in the rural area to explain why a lack of managed care.

One is the regulatory hurdles. In the small areas, a small plan without large numbers of people to spread the cost over, you have a problem in terms of the per unit cost of the regulations. We can come back to that.

The second and third problems are about unwillingness of provider systems that have monopolies to engage in any kind of contracting with private health plans. So that is a serious issue. And I also think that there are ways from an incentive perspective to solve that as well. The third is about not having an infrastructure in the provider community to accept risks.

So as we say, we have some thoughts about how to work with the committee to try to address those issues straight up and to provide more choices.

Senator BAUCUS. Dr. Crystal, I see you want to say something.

Dr. CRYSTAL. Thank you. I would say that many of the States will certainly try to maintain our effort and do some kind of wrap around if there were a universal, defined benefit that would cover everybody in traditional Medicare if it was one that was comprehensible, one that they were able to interface with.

So if you bite the bullet and do some type of a universal, defined benefit, I think at least in that area, you might not lose too much.

Senator BAUCUS. We have to find something because there are a lot of people, not just in Montana, but there are people in addition to Montanans that just do not get the benefit. Medicare HMOs just are not there, even with all the great services out there that provide wonderful services for a lot of people in certain parts of the country, but just not in rural America.

Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

Now, Senator Hatch.

Senator HATCH. Well, welcome to all of you. We are happy to have your testimony.

One of the last hearings we held on this subject, they estimated that universal coverage would cost somewhere in excess of $1 trillion over 10 years which kind of puts a damper on that idea. At least, I can kind of think that even though I would like to see a really good prescription drug package in this Congress.

Ms. Ignagni, in your testimony, you say that the Medicare+Choice cannot successfully deliver pharmaceuticals as part of a Medicare benefit without a sufficiently reliable source of funding. My State of Utah currently does not have any Medicare+Choice plans.

I have talked to representatives of the plans that offer coverage in Utah. And we are told that they pulled out of Utah because they were losing a lot of money. Now, many of the seniors who signed up for Medicare+Choice plans were those who took several medications and tended to be sicker than the average Medicare beneficiary.

In fact, one plan representative told me that if they ever decided to rejoin the Medicare+Choice program, they would never offer prescription drugs again with significant funding. So I would be interested in your thoughts on this.

Utah is a rural State, as is Senator Baucus' State. And increasing Medicare+Choice payments is not going to help the Medicare beneficiaries who I represent if no one is willing to offer the service.

Ms. IGNAGNI. Thank you, Senator. I think you have just made the point more compellingly than I could have about the myth of we are only treating the well.

Senator HATCH. You are off to a good start here. [Laughter.]

Ms. IGNAGNI. Thank you.

Senator HATCH. Sure.

Ms. IGNAGNI. I think that is very pro-actively made. And I think the plans are telling you the truth about the difficulties with respect to managing the care of this population and declining reimbursements. We think that there is more that needs to be done with respect to the Balanced Budget Act.

And I know that the Congress and this committee has a number of remedies before it. And we hope that there will be attention given to the efforts to sustain choice.

In that connection, if discussion is held in this committee and elsewhere in the Congress about going forward with prescription drugs, we think if there are resources allocated in terms of the baseline program in a baseline benefit that our plans would be in a position to do more.

Right now, they have not have any reimbursement for prescription drugs. And they have worked very diligently to provide it because of the essential element of prescription drugs and disease management. So I think that were there to be resources either in Medicare+Choice or elsewhere, our plans would be not only willing, but would be able to do more in this context.

Senator HATCH. Mr. Coppock and Ms. Ignagni, let me just ask you this question. Pharmaceutical benefit managers are discussed in your testimony in particular. In fact, you say that one of the advantages of 90-day supplies received through mail order programs is that co-payments are less expensive than the co-payments of the 30-day supplies.

Now, that is not always the case. I know of circumstances where it is significantly cheaper to get a 30-day prescription filled than to order a 3-month supply through a mail order plant. In other

words, buying prescription through a mail order system does not always guarantee the best price.

I think that can be very confusing for seniors, especially if they are forced to comparison shop for the best PBM. Now, how would seniors know which PBM offers the best price for their prescriptions? And how will seniors know that one prescription may be cheaper if they get it refilled every 30 days?

Now, do not get me wrong. I am a strong supporter of PBMs, but I also believe that these are important questions that need to be addressed.

And Ms. Ignagni, you also mentioned that beneficiaries save money when using mail service for their prescriptions. So I would be interested in your comments as well.

But let me just point to this. I have a receipt here for a 30-day supply. In this case, it is tetracycline 250 milligrams, 60 caplets. A 30-day supply cost $1.45. Now, this health mail order plan charges $12 for a 3-month supply. Now, how does that provide savings to senior citizens?

Mr. COPPOCK. That is a good question, Senator. The comments that we have made in our written testimony were really focused on the employer-sponsored retiree health care programs where retirees generally do not pay retail prices. There is some discount negotiated off of the retail price on behalf of the employer in terms of working with the PBM.

But more importantly, what employers typically do in providing retiree health benefits is to try and steer, especially in the retiree population, people to the mail order programs because in general it tends to be more cost effective for the employer, not in all cases. But in general, it tends to be more cost effective for the employer.

Plus, from the retiree's perspective, typically if you go in retail and buy a 30-day supply of a drug and you go mail order and buy a 90-day supply, a 3 times factor, the co-pays or the cost sharing that the employer asks the retiree to pay are typically not of the same magnitude. Typically, it is more like 1 and a half to two times to use the mail order relative to the retail.

So as an example, an individual retiree may pay $5 as a co-payment for a prescription on a retail basis. They may pay $10 for a co-payment on a mail order basis when they are getting a 3 times supply of that particular prescription drug. So from the retiree's perspective, we feel it is more cost effective.

Ms. IGNAGNI. And I think that Mr. Coppock has given the right answer with respect to the maintenance drugs in the case of congestive heart, cholesterol, those drugs, asthma, and so on.

The only explanation, Senator, that I could give you for that discontinuity would be that perhaps there is an incentive now built in. Tetracycline would not be necessarily on the maintenance list. And so there is need to go back to a physician regularly to see whether or not the individual should continue on tetracycline.

What we have is a major crisis. The CDC has written about it rather prolifically about people becoming too dependent on antibiotics. And it may very well be that the incentives are oriented toward an advise and consent system in the case of tetracycline.

And if that is the solution nor the issue, I would be happy to explore it with you and find out the answer.

Senator HATCH. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Now, we go to Senator Kyl.

Senator KYL. Thank you, Mr. Chairman. And thank you to all of you who are giving testimony here today. The figures regarding cost inflation for prescription drugs are certainly disconcerting, but I would like to offer two perspectives and then ask for your response.

First of all, I think we all appreciate that when Medicare was first created, the use of prescription drugs as the first choice of treatment was relatively rare. The more invasive procedures were the first choice of treatment. And that was what was covered under the initial program.

We are now coming to see that the use of drug treatments is in many if not most cases the first choice. And as a result, we have to consider modifying the government of coverage to reflect that reality.

I think there is another reality. And that is that the percentage of our income, say, at the turn of the last century devoted to food, clothing, and shelter probably was significant. I suspect that we had to work most of the week in order to provide those basic necessities for life.

There was not much available in the way of medical care. And we did not have to pay much for it. But today, there is much more available. And it does not take us very long in a day to earn what we have to in order to cover our food, clothing, and shelter needs.

If you ask Americans, what is most important to them? I suspect they will say, our health care. I mean, I cannot imagine anything else that would have first place.

And so I think Americans have to be prepared both personally and in the various programs that the government may provide to devote more of our income to what is most important to us, health care. It is a reality. And if we are going to try to scrimp and save and provide shortcuts, we are not going to be providing quality care.

Now, that is the kind of fundamental predicament. Then, add the next layer which is that we already have the system that provides good coverage for a lot of people, not perfect coverage for everyone.

And this morning, you testified about the employer-related coverage. And a couple of you talked abut the need to ensure that the choices that people have today and that they are happy with are retained and that we do not upset that apple cart.

I was particularly pleased to hear that the Chairman, who is not listening to me right now when I am about to compliment him, wrote a memorandum to his colleagues in which he said: the extent to which a new drug benefit can compliment rather than supplant current coverage will result in a wiser use of taxpayer dollars and equally important assure that Americans keep the existing drug benefits they really like. I totally with the Chairman on that. It seems to me that that ought to be the direction that we take here.

The final predicate to my question is, given the fact that the Hewitt study shows pretty clearly that at least over the long haul the employers who provide the largest amount of coverage to date

would obviously adjust their plans to reflect a new government plan and that this would not all be positive.

I ask for a little bit of further clarification particularly from you, Mr. Coppock. According to the survey, 20 percent of employers would eliminate prescription drug for ages 65 plus retirees. And of the 80 percent that would retain coverage, 55 percent would do it as a supplement and 25 percent would retain primary prescription drug coverage and accept a subsidy from Medicare.

So you are clearly working around. And obviously, we are all interest in ensuring that we do not crowd out.

So at least maybe I can ask the first two of you who testified for your thoughts before the time runs out here on how we can do that?

Mr. COPPOCK. I am sorry, Senator.

Senator KYL. How we can do that?

Mr. COPPOCK. Well, I think what we saw, what I mentioned in the oral testimony earlier, was that there clearly has been somewhat of a decline in employers who offer coverage. And it is a combination of some current employers who drop coverage and some newer ones who are not offering retirees health coverage.

The one comment I would make though is despite the percentage decrease, Medicare eligible retirees who have employer-sponsored health care coverage has actually increased over that period of time from the latest data available in 1996 to 1998.

The number of Medicare beneficiaries with employer-sponsored coverage went from 11.4 million to 12.4 million. So that is over that period of time when the percentage has decreased.

And that is primarily driven by the fact that when an employer considers or makes any changes to their retiree health care benefits, in virtually all cases, people who are already retired are grandfathered. They are not subject to the changes that go forth prospectively.

Plus, in almost all cases, some group of active employees who are close to retirement with a lot of different definitions of what that might be are also grandfathered into the current program.

So I suspect that the number of Medicare beneficiaries with employer-sponsored care will continue to increase even as the percentage declines.

But your point is a still valid one. I mean, how do we keep employers who are spending in the large numbers that I mentioned earlier in the game? And I think there are a several principles for this committee to consider.

One is trying to keep the new coverage as simple as possible. As you have indicated, our survey showed that a good majority of the employers would like to simply coordinate with the new prescription drug coverage, as they do to the Medicare Parts A and B and the Medicare+Choice system that exists right now.

And then, the other I think is just to find some incentives, be it financial or other, to keep employers interested in spending those dollars in the game.

Senator KYL. Could we hear from Ms. Ignagni?

The CHAIRMAN. Yes.

Please answer.

Ms. IGNAGNI. Very quickly, I think you gave a very set of important answers. And I agree with that. I also think that there are other ways to stimulate additional coverage through choice.

We would like to see choice expanded not just to HMOs, but along with the original intent of the 1997 legislation, PPOs, other options. But there needs to be more stability there. We would like to offer some thoughts about how to deal with that in rural areas.

So we think that there could be additional things that could be done to supplement what is done as a baseline that would be very productive for the society, as well as for the seniors.

Senator KYL. Thank you.

The CHAIRMAN. Senator Kyl, thank you.

Now, it is Senator Breaux's turn.

Senator BREAUX. Thank you, Mr. Chairman. And I thank the panel members. One of the things that CBO tells us is that the cost of providing prescription drugs for seniors has escalated by about 33 percent higher than they said it was going to be last year which is about $1.5 trillion over the next 10 years.

So I would like to ask, in designing any type of a prescription drug program for seniors, one of the great challenges of the Congress is going to be to determine what type of cost containment features should be part of any Medicare prescription drug program.

And Mr. Coppock, Ms. Ignagni, and Dr. Scheppach can make any comment on this.

What are things that are out there in the private sector that have been effective?

I know that the use of generics is obviously one of them. The use of formulas is another. The restriction on first-dollar coverage is another. The restriction of Medigap covering first-dollar coverage are all tools that can be utilized.

What is the experience with all of these suggestions? Or are there others that we need to be looking at?

Mr. Coppock.

Mr. COPPOCK. Thank you, Senator. We mentioned a few, Ms. Ignagni and myself and some of the other members of the panel, in terms of some of the programs. You just mentioned a few in your question, things like formularies, disease management programs.

Obviously, when you are talking about a senior population who has several chronic conditions, as Ms. Ignagni pointed out, the ability to try and understand how to most cost effective and effectively for the individual to manage their care is critical. I mean, you are talking about a large population as diabetes issues, asthma issues, heart disease issues.

So trying to figure out how to best run those programs so that you can not only manage the cost effectiveness of the program, but also provide better care for those individuals I think is critical.

We mentioned the use of PBMs or pharmacy benefit managers. That is not going to solve all of the issues in rural America. But the fact that there are PBMs out there who have a significant mail order presence and a significant network of pharmacies on a retail basis will certainly help manage the cost in terms of providing discounts for a large population, such as the Medicare group.

Senator BREAUX. Ms. Ignagni.

Ms. IGNAGNI. I agree with that. And just to supplement, one thing that you did not mention that we talked about earlier was step therapy. We have talked about mail order. We have talked about using the scientific evidence to make sure that the care is efficacious.

And I think as we look down the horizon, all of us, we have not talked yet today about mapping the genome and what effect that will have on customized prescription drug therapies.

So I think the most important point, Senator Breaux, is to not only build in all the features we know work now, but allow for innovation in the future to be able to continue to offer coverage and sustainability.

So it is not enough for us to tell you what will work today. We believe that it is important for us to tell you how to make it flexible enough so that we can build in those techniques that are yet to be developed to effect continued cost containment and make sure that those benefits are available in the future.

Senator BREAUX. Dr. Scheppach.

Dr. SCHEPPACH. Yes. I think you have to use sort of all of the above. We clearly are not going to do price controls in this country, but I do think you have to put a lot of emphasis on the consumer, make sure that they make wise decisions. They need to be educated. They have to pay a certain amount so that they make good decisions.

I think from the industry's standpoint now, the way that this industry is evolving, is that some, like generics, should clearly have competitive markets. You have some in the middle which are basically all monopolies. You have the three or four companies selling a similar drug. And then, you have on the far end, there is sort of a monopoly on some of the newer drugs.

And I think you have to develop different strategies to push for competition, both in terms of the sellers of the drugs, as well as your managers. You have to set up incentive systems that are highly competition to in fact do that, plus among other things restrictive formularies, utilization, and all of those types of things.

Senator BREAUX. Mr. Coppock, let me ask you another question. If 36 percent of the Medicare eligible folks out in the country are getting prescription drugs through their employer-sponsored retirement health plans, I am concerned and I know a number of members are that if we institute a Medicare prescription drug plan that there would be a significant number of employers who would say, look at what the Federal Government is going to do and we are out of here and what they would walk away from those plans.

I think you indicated that you do not think that that would happen. I mean, a General Motors, if they had all their retirees covered under Medicare, why would they spend, whatever they are spending, $52 million last year, just buying prosac? I mean, why would they say, I am out of here?

Mr. COPPOCK. Well, I think as you design the new proposal, I mean, clearly we need to consider how a very large proponent of the system, namely, employers will react to some of the changes. And as I mentioned in the testimony, the details are going to matter pretty enormously, depending on how the design works, the subsidization and who is eligible, low income.

Senator BREAUX. I mean, any plan we have is going to cover all things. And any plan we have is going to have the government paying a portion of that.

Mr. COPPOCK. I understand.

Senator BREAUX. Let us assume that and say, why would I as an employer want to continue doing it if the taxpayer is going to do it?

Mr. COPPOCK. I understand, the Senator. And I think the prime driver, other than the survey data that we mentioned that said that a lot of large employers would stay in the game, so to speak, is that of all of the major proposals that have been introduced in this particular area, I think as we look at the benefit, it is a relatively small percentage of what employers already provide right now.

So I think if you had a GM or other employers, as an example, who said that Medicare now is going to pick up the bill, the taxpayer is going to pick up the bill, I think you will see a significant reduction in the benefit that is provided to these retirees who have employer-sponsored coverage.

And I am not sure that any large employer or any employer in general would want to see that happen.

Senator BREAUX. Do you think there would be supplemental providers? Or would they still be continuing to be the principal providers?

Mr. COPPOCK. The majority of the employers in our survey, and I firmly believe this, would wrap around the new coverage much like they do for the current Medicare Parts A and B. So they would keep their coverage and coordinate with the new Medicare prescription drug benefit just as they do currently.

Senator BREAUX. Thank you.

The CHAIRMAN. Senator Breaux, thank you.

Now, Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. This is, as I understand it, sort of the last of our hearings on prescription drug benefits. I do not know if that is true, but that is what I have been told.

And it occurs to me that during all of these hearings, we have asked the kinds of questions which I would be prepared to ask any one of you. And it has been kind of a little thing here, a little bit of thing there, a little piece of information here, a little piece of information there. And fundamentally, no progress whatsoever.

And if I had to bet right now, my guess would be that the hearing process in the Senate Finance Committee on prescription drug benefits has failed and that the chance that we will produce something this year as we are currently proceeding, each with our own questions trying to highlight our own particular problems, sort of adds up to not very much.

So I want to make two suggestions. And the Chairman or the ranking member are free to shoot them down if they wish to.

Number one, I can remember when John Chafee and I were doing the children's health insurance program. We were both adamantly against the idea of States taking them on. And we were all for the idea of Medicaid doing it all because it was known program.

It would have worked very well. There would have been equal benefits throughout.

West Virginia was very slow in the case of my State starting. We are now, however, beginning to catch up. And we have a new Governor who is being very aggressive about that. And in that case Governors count a lot, as do legislators.

But the point is, something is happening. Something is increasing on children's health insurance. The Medicaid approach did not work, but something is still happening. And it is good. And it is covering children.

Almost half of Medicare beneficiaries are now receiving, either for all of the year or for only parts of the year, no prescription drug benefits whatsoever. That is a pathetic statement to make from the U.S. Government and the U.S. Congress.

So two points. One, West Virginia, where prices have gone up enormously, 19 percent overall, prescription drugs 28 percent under our State employees program, as we call it PEIA, that is a problem.

On the other hand, West Virginia is getting together. Ray Scheppach, with whom I have worked with for many years when I was Governor of West Virginia, is getting together with a group of other States.

And they like the idea of volume purchasing. And they cannot do it by themselves. And people have pointed out that only the big States, New Jersey, New York, Pennsylvania, etcetera, have made progress. But that does not mean that a group of smaller States combining together cannot do exactly the same thing.

Now, you might say, that will bring uneven results. Some states will do better in terms of benefits. And some will do less well in terms of benefits to which I would say, all right, but that is better than having nothing happen at all which is what we seem to specialize at in this committee and in this Congress.

So I am not necessarily against the idea of West Virginia, for example, joining with Georgia, North Carolina, South Carolina, New Mexico, and Washington if they do to get a multi-State drug purchasing tool because something like CHPS will happen. Some people will get covered. Some seniors will get prescription drugs. They may be uneven, but they will be more than what they are now getting.

So I want to sort of stipulate that as a possibility that I am generally not in favor of devolution when it comes to health care because in the case, we were overwhelmed by the Governors. And the Congress backed off. Clinton backed off. And so it happened, but still there is progress being made.

So I would like to suggest and ask Ray to comment, and Dr. Crystal you obviously want to, on that idea. Since we are not doing anything, go ahead and let the States do something.

The second thing I would like to suggest is that it is not impossible that the Senate Finance Committee and the U.S. Congress or at least the U.S. Senate cannot do something. But what we do is we have these hearings which we all bring up our little nits and score our little points, but there is no sort of over arching, sort of systemic thing going on at least that I am aware of.

I am chairman of the health subcommittee of this committee, but I would never know it. There have been no meeting of our staffs. I have checked that with mine.

It may be that the ranking member and the Chairman are having meetings. And I do not know about that. I mean, they have had some. But there is no sort of systemic approach on the part of the Senate Finance Committee to try to arrive at the most important thing that we can do in this Congress on health care with is a prescription drug benefit.

So I would like to suggest that the health subcommittees starting with the staffs and then going on start a series of very vigorous meetings on prescription drug benefits from the Federal level. And in the meantime, we should be encouraging to the States to do the very best they possibly can.

My time is up. And if the Chairman would allow, I would welcome comment.

The CHAIRMAN. The Chairman will allow.

So is there any comment?

Are you talking about from the panel or Senator Baucus? [Laughter.]

Senator ROCKEFELLER. Oh, no. I assume the Chairman can speak any time he wants. He is the ranking Senator.

The CHAIRMAN. The panel can respond to answer questions and propositions that Senator Rockefeller has put forward.

Dr. SCHEPPACH. I will start off. I will grant you, there is a lot of experimentation now at the State level because the Federal Government has not moved in this area. And they are getting together, looking at the possibility of buying in bulk. You have a lot of these State-only programs, obviously the Medicaid coverage.

But fiscally, in all honesty, there are significant limitations in terms of any kind of comprehensive approach to this. So we continue to think that it is a Federal responsibility, at least some minimum benefit level. That would then allow States to move back and do wrap-arounds. Like a lot of the other components, I think would adjust. And you would end up with a better program.

It appears you have two options. You either take what is going on out there now and try to weave a new benefit package through that. Or you start with a minimal one and allow the rest of the programs to adjust to that.

I think we tend to look more favorably at the second one which is for the Federal Government to move forward even if it is a minimal benefit package and let the States or others fill in around that. I think if you take the approach to weave a new benefit package around the existing ones, you are going to end up with maybe some cost savings, but I suspect a very inefficient, patchwork clinical approach.

Dr. CRYSTAL. I think your points are very well taken. The States clearly from the work that we have done have done a lot of creative things. They have done important things on prospective drug utilization review. For example, one of the things that has not been mentioned is the whole medical errors kind of thing.

And we have found out that a lot of the medical errors people have been talking about pharmacy-related. And States are doing

some very creative things in picking up some of those and dealing with them with their systems.

And in trying to interface pharmacy issues with other aspects of health care, I think there is clearly a creative role for the States. The States need to be kept in this game in some way. Whatever kind of universal benefit there is, if there is a benefit for everybody, there needs to be a way for the States wrap around.

And I think Karen and others have already noted that in thinking about what to do with limited funds, you need to find a way to start with those who are the most in need which is lower income people so that there is going to be some kind of a means tested tier to this to protect those lower income people. And the States are the ones that know how to do that and how to administer that kind of means testing.

So whatever you come up, I think there needs to be some kind of a creative role for the States. And I think the States are interested in doing that and would like to be not just sort of displaced. And whatever you do with the limited amount of money, you can design it so that the States can wrap around it so that there can be the greatest protection for low income people.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. I think before Senator Snowe goes, I am not sure that I am very well in answering right now every point you brought up, but let me just give you a couple of thoughts.

I have been trying to find a happy medium between the criticism of the committee's work last year when we had so many hearings on Medicare and health issues and did not produce a product. And everybody was looking for one on prescription drugs because it was very much a part of the presidential election.

And now, when we are having some hearings, but would like to move forward to see what sort of compromise and product we can put at the members' level, so I have asked my staff to think in terms of not that this would be the last hearing, but that we ought to be sitting down at least at the staff level and seeing what sort of agreements can be reached on legislation prescription drug/Medicare improvement.

We have had 12 bipartisan briefings. We have had two meetings amongst the staff about possibilities of the Subcommittee on Health having hearings.

And the staff will be sitting down in a bipartisan way with staff of the committee to see what sort of consensus there can be on legislation because as a member of the majority party, I think that there may be some people who would like to put this off until next year and maybe not have prescription Medicare program, thinking it gives in to the election year and would be too hot of an issue and maybe even hoping that the Democrats would like to have that happen so that there is an election issue out there. So I think a timetable for me.

And I have not had direct conversation with Senator Baucus on this, but I think that there is a feeling that we need to move something early.

And I for myself would like to do that sometime late July so that we could have the August recess plus the appropriation month of September to consider it and work on it in October because I think

there are some people who would like to put it off until January and February. And consequently, I see that as putting it off and just nothing happening.

So I should have probably visited with you privately about some of these plans, but you know how it is when you spend all your time on taxes and try to run a parallel course of prescription drugs on the one hand and tax reduction on the other hand. And then, Senator Baucus and I are very interested in some issues on trade, fitting them in, that it is sometimes difficult to communicate.

But at least, off the top of my head, those are some of the things I would ask my colleague.

Senator Baucus.

Senator BAUCUS. If I might add, Mr. Chairman, first, I think it is important to recognize, as the panelists here have been saying, the question is not whether or not to enact a prescription drug benefit, but how? And I think you make a good point frankly that we have been perhaps a little slow on the uptake here.

It is also important I think to realize we need the entire $300 billion that the Senate acted on if we are going to have a meaningful benefit because in my judgment, the amount the President has suggested is just too low.

And I think even you, Mr. Chairman, have said that it is a little too low and will not work.

My recollection is that the lower amount that the President suggested would require up to a $2,000 deductible. That is just not going to work. And we need the full $300 billion.

But you make a good point. The States seem to be moving faster than the Congress. And frankly, it is up to us to live up to our responsibilities and provide for our people.

I might say in my State of Montana again, Montana is not doing anything about this. And I know you in West Virginia have the same concerns.

And in addition, this is a lot more complex at the Federal level than it is in the State level. But nevertheless, we should not run away from our responsibilities. We should live up to them. And we will get it done.

And I know the Senator from West Virginia very well. He is probably the preeminent person in the Congress with respect to his knowledge of health care issues. I know how dedicated he is. And I will just say to the Senator that we will find a way. And I pledge to him my efforts because basically it is so needed back home in my State to act very expeditiously this year.

The CHAIRMAN. Before I call on Senator Snowe, remember, Senator Rockefeller, I said to you already in this session as I did to 19 other members of this committee that I hope communication is adequate. Just in case it is not, if there is anything that we are doing that you want to know, you will get an answer. And if you cannot get an answer, you are at least entitled to know why you cannot know. [Laughter.] But in most, I expect in 99 percent of the incidents, you ought to get an answer to your question.

Senator Snowe.

Senator SNOWE. Thank you, Mr. Chairman. I too want to say, Mr. Chairman, that I hope that we can address this issue this year in this Congress. I think we heard the refrain in the last Congress,

they are waiting until after the next election. I hope that does not repeat itself in this Congress.

I certainly consider the prescription drug issue one of the most compelling health issues along side the uninsured. And we ought to be able to reconcile our differences so that the American people and seniors can get the prescription drug benefit that they deserve.

I am really struck that the conclusions that have at least been developed with respect to the employer coverage benefits.

Mr. Coppock, you mentioned in your testimony that your company has done surveys. And you primarily do them for companies with 1,000 or more employees. Is that correct?

Mr. COPPOCK. That is correct, Senator.

Senator SNOWE. Well, I guess it is troubling in the sense that if larger firms are developing, where in fact you say 36 percent of large employers are considering cutting back on the prescription drug coverage. And many have terminated it for future retirees. What does it say for the smaller employer?

Mr. COPPOCK. Well, I think the case there is that it is even more dramatic. I do not have the figures in front of me.

But despite in terms of focusing on the larger employers, I think any research would indicate that smaller employers, when you start to get to less than 1,000 or more employees, by proportion are having much smaller prevalence of retiree health care benefits.

I think clearly you are talking about smaller numbers of people per company there, but the prevalence of retiree health care benefits available to individuals in smaller organizations is much smaller than in larger organizations.

Senator SNOWE. Exactly. But I know in my State of Maine which is predominantly a small business State, we have seen the decline in employer-provided coverage for health insurance, including prescription drugs. I mean, so obviously that is a trend. And it is difficult for large firms to provide it for their retirees. I can only imagine what it means for smaller businesses.

So this clearly is I think a troubling trend on the part of the employers because of the cost particularly of prescription drugs.

Mr. COPPOCK. Yes, I would agree with you, Senator. I mean, we are focusing today obviously on prescription drug issues, but the whole broader health care issue not only for employers, but in general. And we have not focused at all on the pre-65, the early retiree coverage and issues that a lot of employers face right now.

A lot of the time that we spent today is on the that are available and some of the issues in terms of health plans or state plans making those benefits available for employers. I think they are almost equally concerned about how they subsidize retiree health care.

So just to give you an example, in the retirement area for pension plans, a lot of employers have switched from defined benefit type of claims to defined contribution plans through 401(k) legislation. And there are differing opinions on how that has gone.

But it certainly has provided employers the ability to provide a subsidy for people to make available for their retirement. I think that this committee and Congress in general could consider other avenues to help provide more beneficial treatment of subsidies for retiree health care even if there is not an underlying benefit there.

That may develop in the individual marketplaces whether rural or urban. Something, for example, like the 401(k) legislation, if it was enabled to provide withdrawals of that money to use for health care and long-term care also, I think a lot of employers would find that beneficial to help provide some subsidy, maybe not all, but some subsidy for retiree health care.

Senator SNOWE. Well, what incentives would there be for a company to continue to provide prescription drug coverage, for example, for their retirees if the Federal Government were to design a Medicare benefit?

Mr. COPPOCK. Well, I think——

Senator SNOWE. And we talked about the wrap-around program and so on. But what would be the incentive for them to do so?

Mr. COPPOCK. Well, for the many employers, many large employers who have continued to offer retiree health care, and that still is the majority, as opposed to the minority, they have chosen to do so because they have felt that there is a combination of they have an ability to manage their costs and make affordable for the retirees that are covered, as well as retiree health care is still a factor in terms of how they run their businesses in terms of giving the right talent in their organizations.

So I think even with the implementation of a Medicare drug benefit, I think all those issues are still there. I mean, certainly, I am sure there are some employers who would look at Congress enacting a Medicare drug proposal as an opportunity to exit the business, so to speak, of retiree health care at least for post-65 individuals.

I think through our surveys and other testimony, we have shown that it is indicated that it is a minority of those employers. There will be some, but I would suspect that the large majority because of the very generous level of retiree health care coverage they make available, primarily prescription drugs for post-65 individuals would not want to incur the ramifications of diminishing that benefit down to the level of anything that the Congress or this committee might consider for Medicare.

Senator SNOWE. Ms. Ignagni, you mentioned Medicare+Choice. And we had testimony before this committee a few weeks ago that again suggests other troubling trends which is obviously a decline in those programs.

I mean, my State of Maine, for example, does not have any Medicare+Choice. Even with the increase of payments to these programs, a substantial number of programs have been dropped. In 1999, there were 346 Medicare+Choice plans.

Today, there are 176, irrespective of the fact that we have increased the payments. There were some pilot programs that were being developed for competitive pricing. And those have now been dropped.

So I do not see what the future holds for Medicare+Choice when it comes to a prescription drug benefit. I mean, 85 percent of rural beneficiaries lack any access to this type of program. So it does not seem to me that there is going to be an inclination in the future to see this program progress in a way that we could with reliability predicate a prescription drug benefit.

Ms. IGNAGNI. Senator Snowe, let me say two things. One is that the increase in resources post the Balanced Budget Act has not kept pace with the reductions as a result of the Balanced Budget Act. And there has been very little attention thus far.

I know the committee is very interested the regulatory side of things. That is a major issue here. What we have done is looked very closely at the regional phenomena, what has been going on, what the trends are.

And we have come up with a fairly tangible set of set strategies that we would like at the appropriate time to share with the committee about suggestions to deal with the lack of Medicare+Choice availability in rural areas, point number one.

However, you do have a number of areas around the country where 50 percent of the beneficiaries in Medicare+Choice are in counties that have been stuck at 2 percent increases for 5 years now, given the general trend in health care inflation, particularly with prescription drugs.

And we know that most of the plans are still offering prescription drugs. That has created real stresses and strains. So I think more needs to be done to continue the job.

We are also seeing some pick up now in the areas that have been specifically targeted in the last year where we are seeing additional benefits plans indicating they are opening enrollment again and in some cases coming back. So I think the trend is in the right direction, but more needs to be done.

Finally, we have never made the argument that this is one size fits all and that this is all that needs to be done. We think we can play a major role in providing these benefits, but not the exclusive role. We think there needs to be other options, other models. And we have testified to that effect. And we would like to contribute to that discussion.

Senator SNOWE. Thank you.

The CHAIRMAN. Now, Senator Lincoln.

Thank you, Senator Snowe.

Senator LINCOLN. Well, a special thanks to you, Mr. Chairman, for holding this important hearing today and as we examine ways to provide an affordable, voluntary prescription drug benefit to Medicare. It is important for us to understand the different ways that Medicare beneficiaries currently get or do not get drug coverage. I think we can learn a great deal from where we are and where we have been.

And I want to quickly echo some of the comments from Senator Baucus about our rural areas. Obviously, rural beneficiaries are more likely to have poor health and lower income than seniors living in some of our more urban areas. And they also use more prescription drugs.

In Arkansas, 60 percent of seniors live in rural areas. And I am concerned about the limited prescription drug coverage available to them. Only 14 percent of Arkansas employers offer retiree health insurance. And only 2 percent of rural Arkansans are enrolled in managed care.

The Medicare+Choice plans simply do not go to our rural areas much anymore. And we have discussed a little bit about why and what we can do about that. I am hoping that we would talk more

about specifics, as opposed to just terms like "expanding" and "engaging in," but actually going into the route of how we want to see those Medicare+Choice plans beneficial in those areas.

And certainly, Medigap coverage for Arkansans is simply out of reach for most of our seniors for what it provides. Some statistics for us in Arkansas, we are in the top five States in terms of the percentage of our population that are over 55.

One that we are not particularly proud of is, however, that we rank number one in terms of the percentage of our elderly that live in poverty. So some of those options for us are just not a reality for the constituency that we represent.

I would also like to echo some of the comments that have been made already. And that is that we hope that we do not continue to put this project off of providing prescription drugs.

It sounds good in election times, but the fact is that we have to sit down and work through some very, very difficult problems that many of you all have expressed in your testimony and in your questions and answers in order to come up with something that is going to at least get us started. It may not have all the answers.

But if we do not begin somewhere, we are going to put off yet another year and another year and another year in dealing with the issue of not only providing the kind of quality of life that our seniors need and deserve, but also the cost benefit that we can see from that.

And I think particularly from my standpoint of covering a predominantly rural State, that cost benefit is pretty large in terms of the kind of health care facilities that we have available and how we can curb some of those costs through a prescription drug package and keeping a more well aging population.

Just a couple of questions, Ms. Ignagni. We have talked or you have mentioned, and I know Senator Snowe and several others have brought this issue up, about being predominantly rural and therefore the Medicare+Choice plans are really not a big option for us. And you have talked about expanding it and looking at ways.

But what is the bottom line? What is it going to take? Because if we do not do a prescription drug package this year or within this 107th Congress, we have to look at something that is going to get some of these packages out to individuals in rural areas. What is it going to take to get those Medicare+Choice plans into rural areas? Is it just money?

Ms. IGNAGNI. No, actually, it is not. And Senator Baucus was probing on this earlier. And I hope you did not think that I was dodging Senator Snowe's question. I was just responding to the Chairman's request to keep the testimony to the design issues.

But since you have asked, let me give you three issues. One is that all of our members in your respective communities around the country report that the regulatory hurdles of Medicare+Choice are very, very difficult for small plans to handle. We can be very specific about that. There are also very difficult for large plans to handle. We can be very specific about that.

Second, our plans are making a very strong point of the fact that, and it is understandable given the nature of the markets, often when you are in markets with only 1 provider facility, there is not a great incentive for that provider facility to want to contract and

engage in the kind of competition that provider facilities in areas where there are more than 1 would want to engage in.

Third, there is no infrastructure in the rural areas for providers, particularly on the physician side, to accept risks. We have some ideas about how to develop all of these issues.

You all are talking in the rural areas about the problem of how to bring plans into those areas. We have an equally urgent plan issue with respect to how not to jeopardize the plans that are already in other areas and to continue the progress that is being made so we can save them. And they are 50 percent of the beneficiaries there.

So we have strategies for each region, each area. They deserve separate type of strategies because the payment rates are so divergent around the country. That does not, as MedPAC has suggested, mean that you collapse to a mean because you do not then take account of the special needs in various places around the country which the Medicare fee-for-service program has taken account of.

In other words, many times, we are asked the question, why can we not just pay Miami what we pay in Des Moines, for example? And the reason for that is because the cost of goods and services in Miami are a lot higher.

So that is a problem that is indigent to the fee-for-service side. We have the issue and the challenge because it flows out. So we would be delighted to be very specific about the remedies.

Senator LINCOLN. Right. We will look forward to it. I would certainly be happy to send you a note.

Ms. IGNAGNI. And, Mr. Chairman, I would be happy to send it to all the members of the committee if that would be helpful.

Senator BAUCUS. It would be helpful. Thank you.

Senator LINCOLN. All right.

Senator BAUCUS. Specifically, the regulatory problems.

Ms. IGNAGNI. The hurdles, Senator, are quite considerable on the regulatory side. And this is not an industry that has had a reflexive relationship with the government and with HCFA. This is an industry that has tried to make the relationship work.

And there are many legitimate challenges which I would say that I think that we are beginning now to hear resonant throughout the provider community not only in Medicare+Choice, but we have——

Senator BAUCUS. I am sorry. I would just like to see whatever you provide to the committee.

Ms. IGNAGNI. I would be delighted to. Thank you.

Senator BAUCUS. In addition, I want to slightly correct the earlier comment on the point you made about cost being different around the country. That is not the only reason why payment schedules are very diverse. I think they are wrong in many cases.

Ms. IGNAGNI. I was only quoting the MedPAC report which I think was quite well done when they looked at the various reasons for the diversions around the country.

Senator BAUCUS. I understand.

Ms. IGNAGNI. And I think quite appropriately they made the point that there is also a larger fee-for-service question. And then, it flows through to Medicare+Choice.

Senator BAUCUS. Right. But it is just that their payment patterns are just different in different parts of country for reasons unrelated to cost. A lot of this is historical. And it should be remedied.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I also appreciate you holding this hearing and look forward to moving from this hearing into action steps that will lead us to an actual legislative result.

There have been a number of reasons given why we should not be discussing this issue of prescription drugs through Medicare. One of those is the statement that the States can do it, are the more appropriate level of government to do it.

I believe that Dr. Scheppach compelling case this morning as to why that is not an acceptable excuse. Another is that prescription drugs are available to some two-thirds or more of the Medicare beneficiaries through some other financing source. And therefore, it is not the need.

I believe that this hearing has helped to point out the instability and inadequacy of most of those current options. They may on the face appear to provide meaningful benefit, but just below the surface you find that there extreme inadequacies.

The third reason, and which is going to be the basis of my question, is that we should not add a prescription benefit without it being linked to other reform in the Medicare system. In my sense of the matter, that is going to be the most difficult of these questions to adequately respond to.

I recognize that Medicare reform has a number of aspects. It has a financing aspect. It has a political aspect. But since this hearing is intended to talk about design of a prescription drug benefit, I would like to ask this question: what, if any, reforms in the Medicare program do you feel are either required or highly desirable in order to fit in with the design of a prescription drug benefit? Are there some changes that would have to be made in the current Medicare program in order harmonize with a prescription drug benefit?

I would like to ask that question of each of the members of the panel from your own perspective.

Dr. Crystal.

Dr. CRYSTAL. I would say if you wait until to find a way to reform the entire Medicare system as a precondition to adding some prescription drug benefit, you are going to have an awfully difficult time doing something this year. And I am not personally sure that it is necessary to do that.

I was interested in Marilyn Moon's observations at an earlier hearing that adding some type of a universal prescription drug benefit would actually make the whole notion of competition between the traditional plan and Medicare+Choice make more sense. And I have more logic to it because they would be operating from more of a common playing field.

So it is certainly possible I believe to have an infusion of dollars through reasonable mechanisms, particularly something that would protect the lower income people in a way that does not require restructuring the rest of the system.

And whatever you do, as we have heard from the people whose States are predominantly rural, the majority of the beneficiaries are going to be in the traditional system for some time to come. So we really need to think carefully about what is available to them.

Senator GRAHAM. Thank you.

Dr. Scheppach.

Dr. SCHEPPACH. Senator, the only thing I would say is that if you do get into revising Medicare, this whole question of the dual eligibles is getting to be a very, very difficult one for States. It is at the situation now where nobody is managing this population. Nobody is accountable for it. And it is growing. And it is an expensive population.

So somehow cleaning up responsibilities between the States and who runs it in the Federal Government and perhaps federalizing those dual eligibles would be something I think that would be very helpful to the Medicare and Medicaid programs in the long run.

Dr. CHOLLET. Senator Graham, with respect to Medigap coverage, obviously some adjustment to the mandatory coverage in standardized programs would be required. That is not a difficult thing to do.

With respect to the Medicare program overall and its current coverage, I think the failure to cover prescription drugs in fact distorts the use of other covered services in the Medicare program.

And rather than being concerned about adjustments that need to be made in the Medicare program to accommodate the new coverage for prescription drugs, I think quite the opposite is true. There is probably a significant misuse, per Ms. Ignagni's comments, of coordinated care and significant and misuse of covered services in the conventional Medicare program, excessive use relative to what might be needed if prescription drug therapies were more affordable to beneficiaries who do not have Medigap coverage or who have inadequate Medigap coverage.

And I think you would see improvement in the use of those services, certainly rationalization in the use of those services relative to what we have today.

Senator GRAHAM. Thank you.

Ms. Ignagni.

Ms. IGNAGNI. Senator, I think you have asked one of the most provocative questions. And I am not sure my answer is going to measure up, but let me give it a try. I have not really thought about this before. But what we have been talking about throughout the morning here are design features that frankly if you move ahead, and we support moving ahead, will put this committee and the Congress squarely in Medicare in the middle of the patient protection discussion because much of what we have been extolling, the virtues of today are in fact part of what has been very controversial in the area of patient protection.

So on the one hand, we need to move forward. We need to incorporate design features that will preserve and sustain benefits, but also keep the cost under control, but there is a little bit of a disconnect.

Many of us have been talking about scientific evidence. We have been talking about best practices. We have been talking about integration, utilization, review, formularies, etcetera, which has been

the building blocks of much of the patient protection discussion. There is a discontinuity there, number one.

Number two, I think that your question made me think about again to go back to the regulatory side of things. I think quite a lot has to change for us to move forward not only with an additional benefit, but to move forward with the program that can sustain itself.

But that does argue back to beginning to consider how much the government can do by way of cost containment features and not face the stresses and strains that we have faced in the context of patient protection. And finally, I think that more needs to be done so that we do not continue to put at risk the coverage that people through employer plans through Medicare+Choice, through other plans have available now.

So I think all of that needs to be looked at very carefully. That is not to make the argument that we should not move ahead, that we should not do something, but that we should do so with our eyes open and recognizing that primary discontinuity here.

Senator GRAHAM. Thank you.

Mr. Coppock.

Mr. COPPOCK. Senator, from a benefit design perspective, I think employers will tell you that they have two things right now on their wish list with respect to retirees. The first and by far the biggest is the one that we are talking about here today, prescription drugs. To the extent that this committee and Congress in general can take any action in that particular area, I think employers would be thrilled.

The second area which is not probably too far into the future is the whole issue of long-term care. And we have focused a lot today on prescription drug issues and how the whole industry is changing over time obviously from more traditional inpatient type of care to using prescription drug issues. That is why it is such a big issue today and part of our discussion.

But the other thing that has changed with respect to the industry, but the Medicare system has not necessarily caught up, is the whole issue of how do we cover people who need less traditional forms of health care via the long-term care. And that is a very broad definition.

Clearly, Medicare does cover some of those benefits right now. I think it would be well worth the time of Congress to consider how might we adapt the Medicare program to start to facilitate some of the broader needs of people who do not necessarily need acute health care types of issues, but need more skilled nursing, home health care, those types of those programs. I think employers would be very excited about those possibilities.

Senator GRAHAM. Thank you.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Graham.

We have had really a good turnout at this hearing. We have had more than half of our colleagues present. And I appreciate that very much. But I think it also shows how important this subject is.

I have some more questions. So I hope you do not have to leave yet.

First of all, I need to thank Senator Baucus and Senator Lincoln and maybe others as well who brought up the issue about the rural beneficiaries who all are going to have less access to a greater choice of benefits, including prescription drugs. This is also very true in my State of Iowa.

It is equally important to make clear that one of the main focuses of this hearing though is that we want to focus on those who do have drug benefits and how to ensure that these people can keep their benefits because it seems to me it is a simpler solution dealing with the issue.

If we can maintain existing coverage options, then we have more resources that are going to be available to provide benefits to those who do not have such options today. And that would be true more so for rural beneficiaries than it would be probably of urban beneficiaries.

Dr. Scheppach, your testimony states, "There are increasing concerns from some State Medicaid agencies that the drug rebate program no longer adequately meets the needs of State Medicaid programs." So I would like to have some elaboration on that statement.

Dr. SCHEPPACH. Yes. I think what has happened is that you have had an explosion really in the cost of pharmaceutical drugs over the last several years. In some States, it is increasing as much as 24 to 25 percent.

And it is now raising questions about, are in fact States getting the minimum price. Is it being calculated correctly? And because you have such a comprehensive formulary in terms of drugs that are available, is that a way to go?

The problem is that when you start to restrict the number of drugs, which is one of the few ways that you have left to do that, then you raise real questions about whether that is good health policy. So we are just seeing sort of raised now really within the last year or two to begin to question whether in fact that is the most effective way.

The CHAIRMAN. It is not necessarily then a pattern that has worked well enough and the future to great enough to use as a pattern for anything we might be considering.

Dr. SCHEPPACH. I am not really not sure as I said. I think that there are a number of States that are comfortable with it, but increasingly we have a number who are just raising issues.

But again, it has been driven by the fact that this portion of the Medicaid program has really exploded over the last several years. And it is just hard to get independent information on prices and the amount of rebates.

The CHAIRMAN. Dr. Crystal, I would like to quote from your testimony that, "Coordination of benefits is already a difficult problem for State pharmacy programs. It has been difficult for them even to coordinate benefits with the existing limited outpatient pharmacy coverage."

I would like to have you elaborate on that State experience with existing coverage options. And describe in more detail the challenges that the Federal benefit faces in coordinating state efforts.

Dr. CRYSTAL. The first thing that the State programs talk about with coordination of benefits is that they need to have it if they are to coordinate benefits. And they generally define themselves as the last payor, that they need information, who is entitled to what.

And getting that information directly from the beneficiaries is difficult. Beneficiaries do not necessarily know the names of their coverage or what it provides.

Pennsylvania probably has gone the farthest in really developing sophisticated systems, sometimes somewhat contentious, with the health plans, but basically negotiating to get direct access to information as to what has what plan and working through the pharmacists at the front end to require.

The pharmacists typically have these computer point-of-service systems. But you could potentially have a lot of burden of pharmacists, say, in a world where you have competing stand-alone pharmacy policies that are federally subsidized, each one of which has a little bit different kind of a plan. I think that is the kind of scenario that they are very concerned.

They have a number of ideas that they would have, perhaps the option to administer a Federal benefit themselves or that they can get into the business of premium subsidy instead of actually wrapping around coverage. But if they went there, you might find that the State financial contribution kind of being more at a distance disappearing.

And from the public health point of view, which I think is important as well, is the cost containment view, the prospect of drug utilization review. I think the way that pharmacy coverage is going is to be less passively managed.

We have heard that a lot from Karen Ignagni and others that you need to do more than just pay for prescriptions. You need to look really at who is getting what, see if it is appropriate, and see if it is interacting with other drugs that they are getting which means you have to know something about the diagnoses. So they are concerned about fragmentation.

The States have also been interested in linking because a lot of this is tied into heavy expenditures in the dual eligible population which is also in many cases the long-term care population. So thinking about ways that you can integrate care for those populations which is something that the States do.

I have had a little bit of the same kind of struggle that Senator Rockefeller describes. You want to see a universal benefit, but then you come back to what the States are really doing. You say, well, we do not want to flop this off on the States.

And certainly, the States fiscally are not prepared to take it on. They would need the money. But the States are a lot closer to what is happening with people's health care.

And what you want to move towards is something that facilitates integration of prescription drug therapy with other aspects of people's care, as opposed to having something that is quite separate, particularly if it involves a whole new cast of payers.

The CHAIRMAN. My next question might ask you to repeat a little of what you have just spoken about. But let me follow on to your question before I go to Mr. Coppock. You mentioned in your testi-

mony, "Well trained and well equipped pharmacists is critically important to the smooth operation of the drug benefit."

To what extent then have States included pharmacists in the Medicare prescription drug delivery system? And do the States look upon the pharmacists principally as dispensing agents or as active participants in the delivery of medication?

Dr. CRYSTAL. I think the States have been looking to work more closely with the pharmacists. And they are certainly putting in more. Pennsylvania has gone as far as to give computers to local pharmacies so that they can interface effectively with the program.

And I think this is the direction that pharmacies will be involved at the front end. What will typically happen, for example, they will get either a warning message on their computer or sometimes a reimbursement will be denied because there is a question about the clinical appropriateness. And I think these are some of the directions that we can move in.

Pennsylvania, for example, in the 1990's used their system to address the misuse of halcyon which this drug's misuse was causing a lot of clinical problems. And this is the sort of thing that would basically reduce the inappropriate use of long acting benzoazopine drugs by 90 percent.

And I think if you think about the Institute of Medicine's report about what we have learned about all the misuse of pharmaceutical drugs, which in effect is one of the major sources of medical errors, that we need to think about moving in this direction and to sort of more actively manage benefits.

The CHAIRMAN. I do hear from independent pharmacists, more often maybe the smaller town pharmacists in my State. They are very much concerned about their role in anything we do that is massive in the area of prescription drugs. So it seems to me that it is something that we are always going to have to be reminded of as we develop a policy here.

Mr. Coppock, an issue that is commonly discussed in any drug benefit design is the level of premium subsidy the Federal Government should provide to Medicare beneficiaries. There is particular interest where the premium subsidy should all be offered to all beneficiaries and what level should be set, whether the subsidy should be income-related.

Any one of these design features can impact the likelihood of a beneficiary to take up new coverage. An important consideration in determining subsidy level would be the employer response that you have addressed already.

Could you discuss whether certain levels of Federal premium subsidies would encourage employers to maintain existing coverage, to drop it, or just to wrap it around the Federal benefit?

Mr. COPPOCK. Yes, Mr. Chairman. I think we have indicated in the testimony today that the large majority of employers would continue to wrap around the coverage, I mean, regardless of the level of subsidy. And clearly, if there is higher levels of subsidy, they may decide to take a different action.

But I think with respect to a premium subsidy of anywhere from 25, 30, 50 percent, I think for a lot of large employers who are just looking at the benefit that is provided, these employers are going to coordinate their benefit with this Medicare Part T benefit. The

onset of the premium subsidy is meaningless because they have a bias, a stake in making sure that this is successful to help manage their retiree health care cost.

But I think they would view the underlying benefit of much more importance than the actual premium subsidization. And clearly, there are policy issues with the broader Medicare population in terms of how you set the premium subsidy.

But for employers, I think it is more the design of the underlying benefit and how it would coordinate with their programs that is more critical.

The CHAIRMAN. Thank you.

Dr. Chollet, how might Medigap policies, in terms of benefit design and beneficiary cost sharing in plans, be affected if a new Medicare drug benefit is introduced? I am looking here at the extent to which we might be able to be put some life into Medigap policies as a result of doing this.

Dr. CHOLLET. There are a number of ways they could be improved. The 50-percent cost sharing, the 50-percent co-insurance amount clearly is an issue. And depending on the structure of Medicare coverage for prescription drugs, this would be adjusted substantially.

It could be even, however, it could remain as 50 percent of the amount of spending within a margin net of Medicare coverage. So that cost sharing margin, that 50-percent margin probably would be adjusted in some way.

If there were a limit on Medicare coverage for prescription drugs, clearly Medigap coverage could continue to wrap around that limit. The existing limits for Medigap coverage for most Medicare beneficiaries that have this coverage is probably well less than what we are seeing even in the standard policies.

Currently, Medigap policyholders are uninsured, depending on the policy that they hold for more than $3,000 or more than $2,500 of prescription drugs. So that coverage above the limit, it could be adjusted. It would probably be a lot cheaper. And beneficiaries would have more adequate coverage in a Medigap plan.

So certainly, an actuary could price out the adjustments in coverage that it could be imagined for reduced insurance rates, for reduced insurance premiums for Medigap policyholders.

I think that the salient issue is that so few new Medicare beneficiaries have even purchased those benefits over the last 10 years. Clearly, the price is excessive to individuals and to couples who are looking for Medigap coverage. I would expect that the Medigap coverage would be adjusted around a new Medicare benefit. And it would be much lower.

The CHAIRMAN. Thank you.

My last question would be to Ms. Ignagni. This will come from all of your experience in managed care and in designing and delivering prescription drugs to Medicare beneficiaries. If you could, just give me one main piece of advice, if it is not too difficult to single out one, that you would want to leave with those of us on this committee as we consider creating a new drug benefit, alongside other Medicare improvements this year.

Ms. IGNAGNI. I think the key is integration, Senator, because what we have learned about disease management is that care co-

ordination is one of the most valuable things we can do. So the existence of prescription drugs allows you to provide the best care and appropriate care for individuals in this population group that have chronic illnesses. And most of them, as we have looked at the statistics, point number one.

Point number two, in terms of leave behinds would be that not only are you, I know, struggling with as a committee with the question of what you do will work, but it is also the sustainability and the affordability.

So the design features that all of us talked about I think are quite important to pursue so that we are able to continue the job of maintaining this benefit and not completely defeating any cost estimates in terms of how much this will involve.

And I guess a final point would be that we look at the regulatory structure as well to determine a structure or a framework that has the kind of flexibility that encourages incentives and best practices, as opposed to values micromanagement.

The CHAIRMAN. When I discuss this in my town meetings, very often if not in most meetings, prescription drugs come up. And I try to explain to them the historical context. When we started Medicare, the practice of medicine was to put everybody into hospitals. And now, the practice of medicine is to keep people out of hospitals, if you can. And prescription drugs has a very major role to play in that.

So I think what you just said is a natural follow-up. Let me see if what I have said and your one suggestion is, it allows the integration of services for a more holistic approach that is not possible now because prescription drugs is not a part of Medicare.

Ms. IGNAGNI. Exactly.

The CHAIRMAN. Is that a fair summary?

Ms. IGNAGNI. Absolutely.

The CHAIRMAN. Thank you all very much for taking time from your busy schedules to be with us. We appreciate very much your testimony.

The hearing is adjourned.

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

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF DEBORAH J. CHOLLET

Mr. Chairman and Members of the Committee:

Thank you for inviting me to comment on the role of Medigap policies in providing coverage for prescription drugs, and on the potential impact of a Medicare drug benefit on Medigap policyholders, insurers and the market. My comments today are directed to the vast majority of Medigap policyholders: elderly Medicare beneficiaries. The problems that disabled Medicare beneficiaries face in finding and affording Medigap coverage for prescription drugs surely warrant separate consideration: disabled Medicare beneficiaries spend much more out of pocket for prescription drugs than the elderly even when they have Medigap coverage for drugs, and they are less likely than the elderly to have any Medigap coverage at all (NAIC, 2000; Poisal and Murray, 2001). Disabled Medicare beneficiaries comprise just one percent of all Medigap policyholders (NAIC, 2000).

I. HOW MANY MEDICARE BENEFICIARIES HAVE MEDIGAP COVERAGE FOR PRESCRIPTION DRUGS?

In 1989, Congress enacted legislation that standardized commercial Medigap products in order to simplify the Medigap market and eliminate the selling of redundant coverage to Medicare beneficiaries. Since July 1992 (the law's effective date), insurers have been allowed to sell only 10 standard Medigap products, either directly to individuals or though associations. These policies are identified by letter, A through J; policy form A is the Medigap basic benefit, and all other standard policy forms contain variations of additional benefits. Only policy forms H, I and J offer any coverage for prescription drugs.

While insurers were required to standardize new coverage, they were permitted to renew indefinitely all policies issued before July 1992, without converting them to a standard product design. As a result, nearly ⅓ of Medigap policyholders still have prestandard policies.

About ¼ of all Medicare beneficiaries have Medigap coverage, and just 6 percent of these were enrolled in standard policies that covered prescription drugs H, I or J plans in 1999 (Poisal and Murray, 2001; Chollet, forthcoming). Of all Medicare beneficiaries who have purchased Medigap policies since mid-1992, just 9 percent have purchased policies that cover prescription drugs.

The large number of Medigap policyholders with prestandard coverage seem likely to have at least some coverage for prescription drugs, although in fact the benefit designs of these policies are not known. Comparing the number of covered lives that insurers report in prestandard Medigap products to population survey estimates of Medicare beneficiaries with individual (not employer-sponsored) private supplemental insurance,[1] it would appear that nearly all prestandard plans have some coverage for prescription drugs. If we assume this is the case, then in total nearly 40 percent of Medigap policyholders probably have coverage for prescription drugs. Of these, about ¾ have prestandard coverage.

Even this moderate rate of prescription drug coverage among Medigap policyholders, however, varies from state to state. In a few states, more than half of Medigap policyholders (including all prestandard and H, I, or J policyholders) probably had some coverage for prescription drugs in 1999. But in several other states,

[1] Estimates from the Medicare Current Beneficiary Survey indicate that 39.9 percent of beneficiaries with only Medigap insurance have coverage for prescription drugs (Poisal and Murray, 2001).

fewer than 25 percent and as few as 6 percent of Medigap policyholders had any coverage for prescription drugs (Chollet and Kirk, forthcoming). There is no available research that would explain the substantial state-to-state differences in the level and type of Medigap coverage we observe.

II. WHAT DO MEDIGAP POLICIES COVER?

For Medigap policyholders with standard coverage for prescription drugs, that coverage is very limited. And for 3 out of 4 Medigap policyholders who probably have some prescription drug coverage—those with prestandard Medigap policies—coverage for prescription drugs appears to be even more limited.

A. Standard Medigap policies

Each of the three standard Medigap products that covers prescription drugs offers only very limited drug coverage. H and I plans have the same coverage design for prescription drugs; J plans have a higher limit on plan benefits (see Table 1.) However, all leave policyholders with unlimited out-of-pocket expenditures for drugs, and all require 50% cost-sharing. H and I policies pay as much as $1,250 per year for prescription drugs; J policies pay as much as $3,250. However, to reach this level of coverage, policyholders must spend out-of-pocket $2,000 (in H and I plans) or $3,250 (in J plans) the amount of the policies' deductible and maximum coinsurance. Above the plan's annual limits on coverage for prescription drugs ($2,500 and $6,000 per year, respectively), the policyholder has no coverage for the balance of the year.

B. Prestandard Medigap policies

Information from insurers suggests that prestandard coverage for prescription drugs is probably less than that offered in standard H or I plans. AARP's prestandard Medigap policy appears to cover about one-third of Medicare beneficiaries in prestandard Medigap policies; AARP's prestandard policy has a 50% coinsurance rate and a $500 annual cap on the drug benefit.

Other evidence also suggests that drug coverage in many prestandard plans is much more modest than that in standard plans. Because prestandard policies have not been sold to new Medicare beneficiaries in nearly a decade, all prestandard policyholders are now at least age 74, and their use of prescriptions drugs probably is higher than that of younger beneficiaries in standard plans. However, in 1999, the average prestandard plan was about as expensive as a standard H or I plan nationally and in most states (Chollet and Kirk, forthcoming).

C. Evidence of limited Medigap coverage for prescription drugs

Beneficiaries with individual insurance coverage averaged twice the level of out-of-pocket spending for drugs as beneficiaries with employer-sponsored retiree coverage. In 1998, median out-of-pocket spending for prescription drugs among Medigap policyholders with drug coverage was $318, compared to $181 for beneficiaries who reported having drug coverage from an employer-sponsored retiree plan (Poisal and Murray, 2001). Both groups of Medicare beneficiaries reported about the same number of prescriptions per year 23 versus 24.

On average, Medigap policies paid just 42 percent of policyholders' prescription drug costs, compared to 71 percent of costs among beneficiaries with employer-sponsored retiree coverage (Poisal and Murray, 2001). The average rate of insured drug expenses among Medigap policyholders reflects their policies' very high cost-sharing rates typically, 50% after the deductible. It also suggests that most Medigap policyholders incurred expenses within their policy's limit on benefits. However, some obviously exceeded their coverage limits, and potentially by substantial amounts.

Table 1
Prescription Drug Coverage in Standard Medigap Policies

Drug expenses	Plan pays	Policyholder pays
H and I plans:		
• First $250/year	$0	$250
• Next $2,500/year	50% *Maximum benefit: $1,250/year*	50%
• Over $2,500/year	$0	All costs
J plans:		
• First $250/year	$0	$250
• Next 6,000/year	50% *Maximum benefit: $3,000/year*	50%
• Over $6,000/year	$0	All costs

Source: U.S. Health Care Financing Administration (2001).

III. PROBLEMS OF ACCESS TO MEDIGAP COVERAGE FOR PRESCRIPTION DRUGS

While many insurers write Medigap coverage, many write very small amounts of business in some states, often just a few lives. This pattern reflects two aspects of the Medigap market. First the barriers to moving among carriers and policies are substantial, even as policyholders relocate to other states. Second, in many states, large numbers of Medigap insurers are renewing policies, but they are not issuing new policies. Among insurers that are issuing new policies, many are not actively marketing and have issued no new policies in several years in most of the states where they do business.

Medicare beneficiaries' problems of access to Medigap coverage for prescription drugs, however, are more complex than just finding a carrier currently selling coverage. The Medigap market is extensively underwritten insurers are selective about whom they sell policies to. Few states require insurers to offer any Medigap product guaranteed issue, except within six months of enrollment in Medicare at age 65, and then again within six months for a carrier's own policyholders who wish to change plans. Massachusetts (one of three states with a waiver of Federal rules governing Medigap products) is the only state that requires Medigap insurers to offer periodic open enrollment in all Medigap products. In all other states, Medigap insurers may deny coverage in all or most policies that they offer including all that cover prescription drugs for any applicant after age 65.

As a result of these rules, the vast majority of Medicare beneficiaries have access to a Medigap plan that covers prescription drugs literally only once in their lives within a year of enrolling in Medicare at age 65. When beneficiaries are able to change Medigap policies after age 65, the insurer may restart a 6-month waiting period for coverage of preexisting conditions.

A. The supply of Medigap coverage for prescription drugs

Across all states, only about half of Medigap insurers were actively marketing Medigap coverage in 1999. And while, averaged nationally, about as many insurers sell H, I, or J policies as sell other policy forms, this pattern varies by state. In sev-

eral states, just one insurer reported having any open standard Medigap product with prescription drug coverage in 1999 (NAIC, 2000; Chollet and Kirk, forthcoming).

In all states, a guaranteed-issue Medigap policy covering prescription drugs (H, I, or J) was available in at last some part of the state in 1999. However, with very few exceptions, only one or two insurers offered a guaranteed issue H, I or J policy, and enrollment in these policies was very low. Just 2 percent of Medicare beneficiaries with standard Medigap coverage were enrolled in guaranteed issue H, I, or J policies in 1999 (Chollet and Kirk, forthcoming).

B. The price of Medigap coverage for prescription drugs

Standard Medigap premium quotes offer only a rough indicator of actual premium differences among products, and they do not reflect the rating factors (age and gender) that insurers apply to most Medicare beneficiaries. Standard premiums vary widely among carriers for the same policy form.[2] These differences probably reflect noncompetitive pricing, different rating methodologies[3] or both. Moreover, there are strong geographic differences in premiums for the same products and rate classes, probably reflecting geographic variation in enrollment, health status and service use as well as regional variation in competition and prevailing (or prohibited) rating methodologies. Beneficiaries older than age 65 pay a mark-up on the standard premium that reflects their age cohort and also (if accepted for coverage after age 65) their health status. Moreover, women may pay a higher premium in every age cohort than men.

For these reasons, it is very difficult to relate a standard premium quote for one rate class to the premiums that Medigap policyholders actually pay. Nevertheless, examining the level and variation of even standard rates for a single rate class is enlightening when considering why so few Medicare beneficiaries purchase Medigap policies that cover prescription drugs and whether insurers are likely to continue offering these policies.

With funding from HCFA, Weiss Ratings, Inc. recently published rate quotes compiled from all Medigap insurers with open products (just less than half of all Medigap insurers with products in force) in 1998, 1999 or 2000. These rate quotes for men at age 65 typically the lowest rate class are summarized in Table 2.

Three aspects of these rate quotes are especially notable:

- First, relative to any measure of the elderly's income, the average price of a Medigap policy with prescription drug coverage is extremely high. The average standard (and lowest) price of H coverage in 1999 was equivalent to nearly 13 percent of median gross income among the elderly, and more than 8 percent of average gross income. The average standard price of a J plan was equivalent to 19 percent of median gross income and more than 12 percent of average gross income. The very high absolute cost of Medigap policies that include prescription drug coverage probably explains the very low rate of purchase (less than 6 percent) among new Medicare beneficiaries over the last decade.
- Second, average standard rates for H and I products in 2000 were at least 80 percent more expensive than for the most popular Medigap product, policy form F. The average premium for policy form J which offers a $3,000 maximum drug benefit with 50% coinsurance was nearly 2½ times the average premium for policy form F. All other policy forms (some of which contain non-drug benefits much more similar to H, I or J than F) were less expensive than F, averaged nationwide. These price differences at age 65 are probably the main reason that Medicare beneficiaries at age 65 are unlikely to buy Medigap policies with drug coverage. After age 65, Medicare beneficiaries may be denied access to drug coverage at any price, if they are unable to identify one of the few Medigap insurers with an open, guaranteed issue product.
- Third, the annual growth in premiums for Medigap products that covered prescription drugs has been extraordinary, apparently causing problems for both beneficiaries and insurers. Rate quotes for H plans in 2000 were nearly 50 percent higher than in 1998; in one year (1999–2000), standard premiums in H plans jumped 34 percent. Standard rates for I and J plans also rose steeply (34

[2] Weiss Ratings, Inc. (1999) reported standard rates for plan A of $496 (Labor Union Life) and $1,220 (Bankers Life and Casualty Company) for a man at age 65 in Bakersfield, CA. In Billings, MT rate quotes for a J plan included $1,518 (Blue Cross Shield of MT) and $3,453 (National States Insurance Company).

[3] Insurers may rate Medigap polices on an entry-age (or issue-age) basis, on an attained-age basis, or on a community-related basis. As of May 1999, at least six states prohibited Medigap insurers from using entry-age rating, at least ten prohibited attained-age rating, and at least 8 required community rating (NAIC, 2000).

percent and 27 percent, respectively, between 1998 and 2000).[4] By comparison, standard rates for F plans rose just 12 percent between 1998 and 2000, approximately 6 percent per year.

Table 2
Standard Medigap Premiums for a Male, Age 65

	Policy form:									
	A	B	C	D	E	F	G	H	I	J
1998	$631	$875	$1,065	$900	$936	$1,164	$1,071	$1,573	$1,803	$2,408
1999	$698	$947	$1,151	$988	$1,069	$1,233	$1,131	$1,747	$1,980	$2,624
2000	$766	$1,026	$1,239	$1,050	$1,107	$1,301	$1,175	$2,347	$2,423	$3,065
As a percent of premium for policy form F:										
1998	54.2%	75.2%	91.5%	77.3%	80.4%	100.0%	92.0%	135.2%	155.0%	206.9%
1999	56.6%	76.8%	93.3%	80.2%	86.7%	100.0%	91.7%	141.7%	160.6%	212.8%
2000	58.9%	78.9%	95.2%	80.7%	85.1%	100.0%	90.3%	180.4%	186.2%	235.6%
Percent change:										
1998-2000	21.4%	17.3%	16.4%	16.6%	18.2%	11.8%	9.8%	49.3%	34.4%	27.3%
1999-2000	9.8%	8.4%	7.7%	6.2%	3.5%	5.5%	3.9%	34.4%	22.4%	16.8%

Source: Weiss Ratings, Inc., 2001 (www.weissratings.com/NewsRelease/Latest/index.html).

Very high premium growth is very problematic both for policyholders with health problems and for Medigap insurers. Medicare beneficiaries who drop H, I or J coverage because they are unable to pay escalating premiums may have no alternatives available to them other than plan A (if their insurer is willing to down-grade their coverage to A) or a Medicare+Choice plan (if one is available in their area). The somewhat faster growth of standard rates charged for plan A coverage (which every Medigap insurer is required to sell) suggests some high-risk people may in fact be moving into plan A from other standard Medigap policies. Policyholders who abandon Medigap policies that are entry-age priced also abandon an asset the front-loaded premiums that they paid in earlier years—and pay a penalty to enter any other entry-age rated Medigap plan, even if they are able to pass the insurer's underwriting screen.

For Medigap insurers, rapidly increasing premiums can generate an adverse selection spiral (sometimes called a "death spiral") a phenomenon in which rising premiums encourage healthier policyholders to abandon coverage, and the higher medical costs of remaining policyholders then drive still higher premiums. The fact that Medigap policyholders are aging faster than the Medicare beneficiaries suggests that adverse selection is a growing problem in the Medigap market as a whole, as well as for individual Medigap insurers.[5]

Concerned about an adverse selection spiral, insurers are likely to close products where costs and therefore premiums are escalating rapidly. The propensity of insurers to close policies that have poor cost experience probably explains the large number of Medigap insurers carrying closed blocks of business and the relatively small number actively marketing coverage to Medicare beneficiaries.

III. IMPLICATIONS OF A MEDICARE DRUG BENEFIT ON BENEFICIARIES AND EXISTING MEDIGAP COVERAGE

On the whole, a Medicare drug benefit could have a very positive impact on Medigap policyholders and also on the Medigap market. Obviously, it would assist most Medigap policyholders who have no coverage at all for prescription drugs and

[4] Evidence offered in an NAIC survey of states suggests that Medigap premiums rose steeply in earlier years as well. Between 1996 and 1998, average standard rates for Medigap policies (in 43 responding states) rose 22 percent. Only about ½ of this increase was attributed to an increase in Medigap costs for Medicare-covered services (NAIC, 2000).

[5] The American Academy of Actuaries (2000) concluded that the block of standard Medigap policyholders is aging, both for new issues and renewals. Between 1996 and 1998, the average age in both groups increased by one year. Over the same period, the number of Medigap policyholders declined, as the number of Medicare beneficiaries rose. These trends suggest a growing problem of adverse selection in the Medigap market overall.

who are locked out of prescription drug coverage after age 65. However, a Medicare drug benefit also could address at least three serious and growing problems in the Medigap market:

- Medigap lock-in in prestandard plans;
- very fast growth of premiums for Medigap policies that cover prescription drugs; and
- the failure of competition among Medigap policies that cover prescription drugs.

None of these problems in the Medigap market is likely to be addressed successfully except at the federal level.

A. Medigap policyholders without coverage for prescription drugs

Most Medigap policyholders about 60 percent have no coverage for prescription drugs. These include 90 percent of all Medicare beneficiaries who have purchased Medigap coverage in the last ten years (that is, those in standard Medigap plans). The low rate of purchase among new beneficiaries reflects both the very high price of these plans relative both to any measure of income among the elderly and also relative to other standard Medigap plans that do not include this coverage. The fact that new Medicare beneficiaries are less likely to buy any Medigap coverage than their predecessors suggests that even the current low rate of prescription drug coverage among new Medicare beneficiaries will continue decline. Underwriting restrictions in the Medigap market make it very difficult for Medicare beneficiaries to buy new prescription drug coverage at any time after age 65.

B. Medigap lock-in for aging Medicare beneficiaries

Three out of four Medigap policyholders with prescription drug coverage are in prestandard Medigap plans. These plans apparently offer very meager coverage for drugs. But all policyholders in these plans are now at least age 74. Because in most states Medigap insurers may deny issue to Medicare beneficiaries after age 65, prestandard policyholders typically have no alternative Medigap option other than plan A (if their current carrier is willing to downgrade their coverage) or a Medicare+Choice plan (if an M+C plan is available in their area). If they enter an M+C plan and wish to leave (or the plan withdraws), they may not reenter their prestandard plan and they are not guaranteed issue into any standard Medigap product that covers prescription drugs. Lock-in for Medigap policyholders in either standard or prestandard plans is already a serious problem, and it is likely to worsen especially for policyholders in prestandard plans.

C. Very fast growth of premiums for Medigap coverage of prescription drugs

Nationwide, expenditures for prescription drugs have increased markedly over the last several years. Because Medicare beneficiaries in general use more prescription drugs than other insured populations, growth in drug prices and utilization inevitably affect the cost of Medigap policies more than the cost of private insurance for the working population, despite the limited drug benefits available in Medigap plans.

The very fast growth of premiums for Medigap policies that cover prescription drugs at least 50% over the last two years for plan H, the least expensive standard plan with drug coverage is an obvious and serious problem. Fast premium growth forces some policyholders to abandon their Medigap coverage. Many may have no alternative option that would provide drug coverage. Moreover, they may be unable to qualify for any alternative Medigap coverage at all, unless they live in one of few states that require insurers to hold periodic open enrollment in A plans, at least for current policyholders.

Spiraling premiums for insurance products, however, create other problems of access. Insurers often respond to spiraling premiums by closing their products; that is, they are likely (under pressure from state insurance commissioners) to continue to renew existing coverage, but not to sell any new coverage. Obviously, a scarcity of insurers actively marketing coverage poses problems even for new beneficiaries, and it may worsen older beneficiaries' problems of access as well.

D. Failure of competition in Medigap coverage for prescription drugs

It is likely that at least one reason for the rapid growth in even the lowest premiums (for men at age 65) for standard Medigap coverage that covers prescription drugs relates to the disadvantage that Medigap policyholders have in buying prescription drugs. Medigap policyholders pay full retail price. The diffusion of insurers' business across many states (following policyholders as they move) and the limited coverage of prescription drugs in Medigap plans provide no particular capability or incentives for Medigap insurers to bargain with prescription drug manufacturers or retailers for lower prices. Federal agencies and state Medicaid programs pay substantially lower prices for prescription drugs than many other purchasers most espe-

cially individuals who are either uninsured or, the equivalent, buy coverage from a passive insurer.

The range of standard premiums among insurers in the same market, for identical standard plans, suggests that even new Medicare beneficiaries still have trouble finding their way in the Medigap market. Thus, even if Medigap insurers were able to negotiate preferred prices for significant blocks of business in selected states, it is unlikely that they would be rewarded with much new market share.

Moreover, if some insurers were to enable access to prescription drugs at reduced prices (thereby reducing premiums for Medigap policies that cover prescription drugs), they might be ill-advised to do so. In effect, these insurers would position themselves for adverse selection by Medicare beneficiaries who, at age 65, have an immediate need for prescription drugs. For these reasons problems of consumer information and fear of adverse selection it is unlikely that any Medigap insurer would elect to negotiate preferred prescription drug prices for policyholders, even in states where they may hold relatively large blocks of business.

IV. CONCLUDING OBSERVATIONS

In summary, the Medigap market is not now a good source of coverage for prescription drugs, and there are many reasons to expect that it will become much worse. Of all Medigap policyholders with prescription drug coverage, ¾ are in locked in prestandard plans, with M+C plans as their only potential alternative source of coverage for prescription drugs. Only 9 percent of Medicare beneficiaries in the past ten years have purchased any Medigap plan that covers prescription drugs.

Medicare coverage of prescription drugs might offer advantages both to policyholders and insurers in the Medigap market. On the whole, these advantages would appear to outweigh any disadvantages. Medicare drug coverage would supplant at least some existing Medigap coverage for drugs, but it would offer an opportunity to restructure drug coverage in standard Medigap plans to provide more rational and adequate coverage such as retirees in employer-sponsored retiree plans have. It also could allow Medigap policyholders to purchase prescription drugs at less than "full retail" prices; these prices have become increasingly steep as large buyers (including Federal and state governments) have negotiated preferred prices. And, finally, by stemming the hyper-growth of Medigap premiums for policies that cover prescription drugs, Medicare coverage of prescription drugs could stabilize the Medigap market offering some cost relief to consumers who are locked into Medigap policies, and also a remedy to insurers that ultimately will close Medigap policies experiencing steeply rising costs.

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PREPARED STATEMENT OF STEVE COPPOCK

SUMMARY OF ORAL TESTIMONY

Current Status of Retiree Health Benefits

- Employer-sponsored retiree health coverage is the largest source of supplemental health insurance for Medicare beneficiaries, providing coverage to 36 percent (13.8 million Medicare beneficiaries) of the non-institutionalized Medicare population in 1998.
- Employers are the largest source of prescription drug coverage for Medicare beneficiaries, with 33 percent (12.4 million) of non-institutionalized Medicare beneficiaries receiving drug coverage through employer-sponsored retiree health plans in 1998.
- Of all Medicare beneficiaries with drug coverage (27.8 million beneficiaries in total), nearly 45 percent (12.4 million beneficiaries) have employer-sponsored retiree drug coverage.
- Large employers are the primary sponsors of retiree health care coverage and the proportion of employers offering retiree coverage decreases with firm size.
- Medicare-eligible retirees appreciate the value of their employer-sponsored health benefits. Employer-sponsored retiree health insurance typically offers more generous coverage than other private health insurance, such as providing unlimited drug benefits with no caps. Retirees in employer-sponsored plans receive more in drug benefits and pay less in out-of-pocket expenses than beneficiaries in Medicare+Choice plans and Medigap plans.
- Medicare-eligible retiree drug benefits are typically part of retiree health coverage and do not have separate premiums.
- In an effort to balance access, choice, quality and affordability in retiree drug coverage, employers use several tools to control utilization and costs, such as mail-order programs, disease management programs, and pharmacy benefit managers (PBMs).

Trends in Coverage

- Even with these tools, Medicare-eligible retiree drug expenditures have been growing more rapidly than other health expenditures and are projected to continue to rise with at least 15 percent annual trend expected from now until 2003. Prescription drug benefits represent a significant portion—40 to 60 percent—of the total cost of the retiree health care benefit for Medicare-eligible retirees after accounting for Medicare, and will increase to as much as 80 percent of Medicare-eligible retiree health costs by 2003.
- In the aggregate, employers will spend approximately $22.5 billion on prescription drug coverage for Medicare-eligible retirees in 2003, increasing to $37.1 billion in 2009.
- The prevalence of employer-sponsored health coverage for Medicare-eligible retirees has declined in recent years, with some employers dropping coverage and few newer employers adding retiree health coverage. However, in the vast majority of cases where large employers have terminated retiree health coverage, the change was made on a prospective basis, for future retirees only.
- A Hewitt survey of large employers indicates that 36 percent of large employers are considering cutting back on prescription drug coverage for Medicare-eligible retirees over the next three to five years.

Medicare Prescription Drug Benefit Proposals

- Discussing the effects of a new Medicare drug benefit on employer-sponsored plan benefits and the retirees who receive them is difficult without knowing specific details about the new Medicare drug coverage.
- It is probably in the common interest of Medicare, of retirees, and employers if some positive incentives were added to encourage the retention of these employer-sponsored retiree health programs because of the high levels of employer spending on drugs for retirees, and the relatively generous benefits retirees in these plans enjoy.
- After accounting for proposed Medicare drug benefits, employers would still spend approximately 71–77 percent of their current total per retiree cost in 2003 for Medicare-eligible retiree drug benefits when wrapping-around a proposed drug benefit, and employer spending would be even higher if they pay all or part of any retiree premium required for the Medicare drug benefit. Employers would achieve limited financial relief because the proposed Medicare drug coverage represents a minority portion of the more generous employer-sponsored retiree coverage.

- If a $4,000 federal stop-loss provision is added that would somewhat reduce employer spending, but even then employers would still be spending approximately 66 percent of the total drug cost per retiree in 2003.
- Most of those employers (80 percent) currently providing retiree health benefits have indicated in surveys that they would most likely retain drug coverage in response to the creation of a new Medicare drug benefit.
- The preferred employer response to a new Medicare drug benefit would be to wrap-around, or supplement, the new drug benefit and the specifics of the proposed drug benefit coordination should require the least amount of administrative complexity and expense.
- Retiree out-of-pocket costs would be dependent on the subsidy level in the Medicare program, with retiree out-of-pocket costs decreasing as the subsidy levels increase under Medicare.
- Employers base their decisions regarding their retiree health programs on many factors, besides a potential Medicare drug benefit, so the Committee may wish to consider additional ways of encouraging employers to sponsor retiree health programs.

STATEMENT OF STEVE COPPOCK AND ANDREW ZEBRAK

Thank you for the opportunity to testify on the current prescription drug environment for Medicare beneficiaries with employer-sponsored coverage, and the implications of a new Medicare prescription benefit on that environment. I am Steve Coppock, a principal at Hewitt Associates, which is a global management consulting and benefits delivery firm and the largest employee benefit consulting firm in the U.S., by revenue.

Hewitt primarily works with large employers that have 1,000 or more employees. For example, Hewitt clients include more than two-thirds of the Fortune 500 employers. Our testimony will draw from a report Hewitt prepared for The Henry J. Kaiser Family Foundation, "The Implications of Medicare Prescription Drug Proposals for Employers and Retirees" (July 2000). It will also draw from other Hewitt data and from our experiences in working with large employers in attempts to better position their retiree health benefits, including prescription drug benefits.

A widely acknowledged shortcoming of the Medicare program is its exclusion of outpatient prescription drug coverage. Prescription drug expenditures represent a growing portion of Medicare beneficiaries' health costs, especially for beneficiaries without supplemental health insurance.

As Congress considers proposals to reform Medicare and develop a prescription drug benefit for Medicare beneficiaries, this Committee is to be commended for its efforts to understand the impact of these proposals on employer-sponsored retiree health coverage. Many Medicare beneficiaries have employer-sponsored retiree health benefits with generous drug coverage, which is of significant value to them.

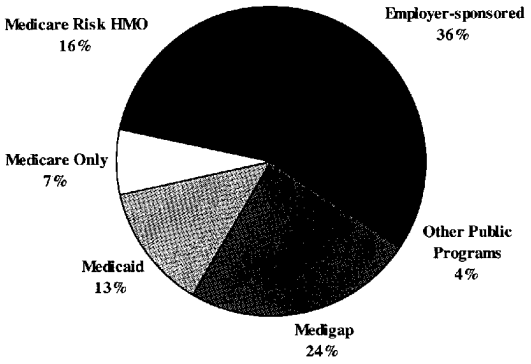
Our testimony will begin with a description of what employers provide to retirees in terms of prescription drug benefits and recent trends in coverage. Then, we will address the potential impact a Medicare prescription drug benefit could have on employer-sponsored retiree coverage and on retirees included under this coverage.

CURRENT STATUS OF EMPLOYER-SPONSORED RETIREE HEALTH COVERAGE FOR MEDICARE BENEFICIARIES

Largest Source of Supplemental Coverage to Medicare

Employer-sponsored retiree health coverage is the largest source of supplemental health insurance for Medicare beneficiaries. The most recent Health Care Financing Administration (HCFA) data available (1998 Medicare Current Beneficiary Survey) indicates that 13.8 million Medicare beneficiaries, 36 percent of the non-institutionalized Medicare population, had employer-sponsored supplemental coverage. The 13.8 million includes some beneficiaries with both retiree coverage and individually purchased Medigap insurance (Figure 1).

Figure 1: Supplemental Health Insurance of Medicare Beneficiaries, 1998



Total = 38.1 million non-institutionalized Medicare beneficiaries, 1998

Note: Numbers may not add to 100 percent due to rounding.

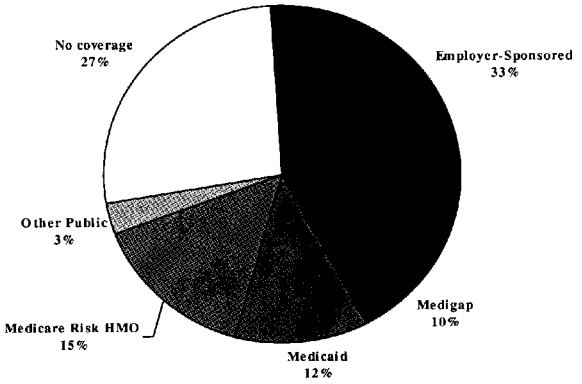
Source: Poisal, John, and Murray, Lauren, "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage," Health Affairs, March/April 2001.

Largest Source of Prescription Drug Coverage

Furthermore, employers are the largest source of prescription drug coverage for Medicare beneficiaries. According to the same HCFA data (1998 Medicare Current Beneficiary Survey), 90 percent of beneficiaries with employer-sponsored retiree health coverage had prescription drug coverage. Among the large employers in the Hewitt database, the percentage is even higher, with more than 95 percent of the large employers providing drug coverage as part of retiree health plans.[1] In total, 33 percent of non-institutionalized Medicare beneficiaries received prescription drug coverage through employer-sponsored retiree health plans in 1998 (Figure 2). Retirees with employer-sponsored prescription drug coverage comprise nearly 45 percent (12.4 million beneficiaries) of all Medicare beneficiaries with prescription drug coverage (27.8 million beneficiaries in total).

[1] Hewitt has monitored the benefit provisions of major employers since 1972 through annual updates to its database of client companies. The 2000–2001 Hewitt Associates SpecBook™ summarizes the benefits offered to salaried employees of 1,020 major U.S. employers, including 85 percent of the Fortune 100 and 58 percent of the Fortune 500 companies. In Hewitt's experience as a consultant to large employers, the retiree health coverage among employers in the database is generally representative of the Fortune 500 employers. The database represents coverage offered by large employers, which are the prime sponsors of retiree health coverage.

Figure 2: Prescription Drug Coverage of Medicare Beneficiaries, 1998



Total = 38.1 million non-institutionalized Medicare beneficiaries, 1998

Note: Numbers may not add to 100 percent due to rounding.

Source: Poisal, John, and Murray, Lauren, "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage," Health Affairs, March/April 2001.

Typical Employer-Sponsored Retiree Health Coverage

Hewitt estimates that absent any changes in law and assuming the continuation of current coverage, employers will spend in the aggregate approximately $22.5 billion on prescription drugs for Medicare-eligible retirees in 2003, increasing to $37.1 billion in 2009.

Large employers are the primary sponsors of retiree health care coverage. Research indicates that very large employers are much more likely to sponsor retiree health insurance than other employers, with the percentage of firms offering retire health coverage decreasing as the size of the firm decreases. Retiree health coverage is least prevalent among small group health plans. For example, 52 percent of jumbo employers (5,000+ employees) offered retiree health benefits in 2000, compared with 35 percent of midsize firms (200–999 employees) and 7 percent of small firms (10–24 employees).[2] According to U.S. Labor Department data, in 1997, 43 percent of all full-time employees in private medium and large firms (100 or more employees) had retiree health coverage available, compared to only 16 percent of full time employees in firms with fewer than 100 employees (1996).[3]

Employer-sponsored retiree health insurance typically provides more generous drug coverage than other private health insurance. Large employers usually provide unlimited drug benefits, whether the benefit is provided by a fee-for-service Medicare supplement or through Medicare+Choice (M+C) plans. In the latter case, employers negotiate for their retiree group coverage and add drug benefits to the standard coverage otherwise available to individual retirees through the M+C plan. However, individual coverage through M+C plans and Medigap plans generally impose annual (or quarterly) prescription drug benefit limits.

According to Hewitt data, roughly 97 percent of employer-sponsored plans have no annual drug benefit caps. In 1999, 95.5 percent of large employers had unlimited drug benefits available through their M+C plan offerings, about 4 percent had limits of $1,000 or more, and less than 1 percent had limits under $1,000, according to

[2] The Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000.

[3] U.S. Department of Labor, *Employee Benefits in Medium and Large Private Industry Establishments, 1997; Employee Benefits in Small Private Industry Establishments, 1996.*

the Hewitt Health Value Initiative (HHVI) database.[4] Annual drug caps are even less common under employer-sponsored fee-for-service supplemental polices than under employer-sponsored M+C plans.

The majority of employer-sponsored retiree health plans contain specific provisions for prescription drug coverage separate from the specific deductibles, copayments or coinsurance for other medical expenses. For example, an indemnity plan may have a $250 deductible and 20 percent coinsurance for non-drug medical expenses, with a separate $5 copayment per prescription. HHVI data indicates that over 95 percent of large employer plans have separate prescription drug benefit designs. However, employers virtually never charge retirees a separate premium for the drug coverage.

Retiree health plans typically have a fixed amount, or copay, that a beneficiary pays when purchasing a drug, to help control costs. Copays may vary by major categories of drugs, i.e., generic versus brand name drugs, or whether the drug is on an approved list under the program (called a formulary). Generic drugs would have the lowest copay requirement and brand name drug copayments would have a higher copay. The generic/brand copay arrangement is the most common approach currently used with retirees, but three-tier copays are increasingly being introduced (as discussed further below).

Although there is some variation among retiree plans, more than half have copays of $5 for generics and $10 or more for brand name drugs, according to HHVI data. Approximately 7 percent of plans have no copay requirements for brand name or generic prescription drugs. The most common copay structure (in 1999) is $5 for generic drugs and $10–$14 for brand-name drugs.

A growing number of employers are using three-tiered copayment systems—with different copayment amounts for different categories of medications—to influence utilization of more cost effective medications, e.g., generic and formulary drugs, while still allowing access to non-formulary products at higher patient copays. Under a three-tier arrangement, the lowest copay would again be for the generic drugs, e.g., $5. Brand name drugs are then categorized depending on whether they are on the formulary or not. The formulary brand copay would then be higher than the generic copay, e.g., $15, and the non-formulary copay would be even higher still, e.g., $35 to $50. But a wide difference may exist in the spread between the formulary and non-formulary copays, depending on the plan. Large employers who have adopted three-tier programs have done so in an effort to balance access, choice, quality and affordability, saying that without a three-tier approach, affordability would have suffered.[5]

Three-tier copays may become even more common in retiree health plans over the next several years as employers and Medicare+Choice plans seek additional ways of managing sharply rising expenditures on retiree prescription drugs.[6]

Formularies

Retiree health plans typically use formularies as part of the drug benefit and have been shifting in recent years from open formularies to closed and partially closed formularies.[7] A survey of health plans (including current employees and retirees) indicates that 25 percent of employers used an open formulary, 19 percent used a closed formulary, and the majority (56 percent) used a "selective/partially closed formulary."[8]

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[4] Hewitt Health Value Initiative™ is an annual study that collects plan costs, designs, health plan performance measures and employee satisfaction survey results for over 300 large employers. It includes plan design information for 1,000 plans and one million lives for post-65 retiree health plans.

[5] Shelly Reese, "New Concepts in Health Benefits: Three-tier drug copays,' *Business & Health*, April 2000.

[6] "The movement toward three-tier plans is so pervasive that last year alone the percentage of commercial health plan members enrolled in such programs nearly doubled to 57 percent from 29 percent, according to Caredata's annual survey of nearly 25,000 members. Most self-insured plans are not among the early adopters.... Only about one in five self-insured plans currently uses a three-tier plan," Shelly Reese, "New Concepts in Health Benefits: Three-tier drug copays," *Business & Health*, April 2000. In a separate but similar report, 67 percent of health plans offered a three-tiered copayment option to their members in fall 1999, up from 36 percent in spring 1998, according to Scott-Levin, *Managed Care Formulary Drug Audit*.

[7] Open formularies provide coverage for virtually all drugs with no financial penalty, regardless of whether they are on the formulary list. A closed formulary means that a drug that is not on the formulary list is not a covered benefit. Partially closed formularies cover formulary drugs and selected non-formulary drugs for which coverage is determined by prior authorization.

[8] Novartis Pharmaceuticals, *Pharmacy Benefit Report: Trends and Forecasts*, 1998 Edition.

Pharmacy Benefit Managers

A majority of employers have discontinued their reliance on medical insurance carriers to process claims for prescription drugs. Instead, Hewitt's Health Value Initiative™ data indicate that approximately 70 percent of self insured employers use a pharmacy benefit manager (PBM) to manage the pharmacy network and process those claims. Under the PBMs' administration, over 98 percent of claims for prescription drugs are submitted electronically by the pharmacy that fills the prescription. The PBMs typically adjudicate the claims through a standardized process within 60 seconds or less.

The PBMs apply consistent discounted reimbursement formulae for all claims. In addition, employers also receive a portion of the rebates that PBMs earn from pharmaceutical manufacturers.

In addition to serving as the systems and financial management arm, PBMs also provide a myriad of cost management programs for employer-sponsored retiree health plans. These programs can range from basic activities, such as requiring prior authorization for specific prescription drugs to designing and implementing disease management programs that can be applied for an employer's retiree population. For example, many PBMs are heavily involved in prescription-drug focused clinical treatment programs for conditions such as diabetes, asthma and depression.

Mail-Order

Another tool offered by PBMs and commonly utilized by employer plans is mail-order programs. These mail-order programs may contain costs through increased use of generic drugs and lower prices for covered drugs via volume discounts. Approximately 70 percent of plans in the Hewitt database (HHVI) offer mail order programs to retirees. Mail-order programs are appropriate for many retirees that use maintenance medications for chronic conditions and provide several advantages to retirees such as home delivery, lower costs than in a retail pharmacy, and lower copays for a 90-day supply than the copays would be for three 30-day supplies.

Value to Retirees

Medicare beneficiaries with employer-sponsored retiree drug coverage receive higher drug benefits and pay less in out-of-pocket drug expenditures than beneficiaries in Medicare+Choice (M+C) plans and Medigap plans. Thus, retirees are highly satisfied and value their employer-sponsored health care coverage and drug benefits. Data from the Medicare Current Beneficiary Survey (MCBS) illustrates the more generous coverage under employer-sponsored plans compared with M+C and Medigap plans.

For example, based on HCFA MCBS data, average drug expenditures per person in 1998 were $1,072 for beneficiaries with employer-sponsored coverage, $682 for beneficiaries in M+C plans, and $947 for beneficiaries with Medigap coverage. (These employer-sponsored spending amounts would be about 50 percent larger if trended forward to 2001). Retirees with employer-sponsored coverage paid proportionately less out-of-pocket in 1998 (29 percent), than beneficiaries in M+C plans (40 percent) or beneficiaries with Medigap coverage (58 percent). Between 1995 and 1998 alone, retiree out-of-pocket expenses grew considerably faster under M+C plans and Medigap than for those with employer-sponsored coverage, where the retiree out-of-pocket share actually declined from 31 percent to 29 percent.

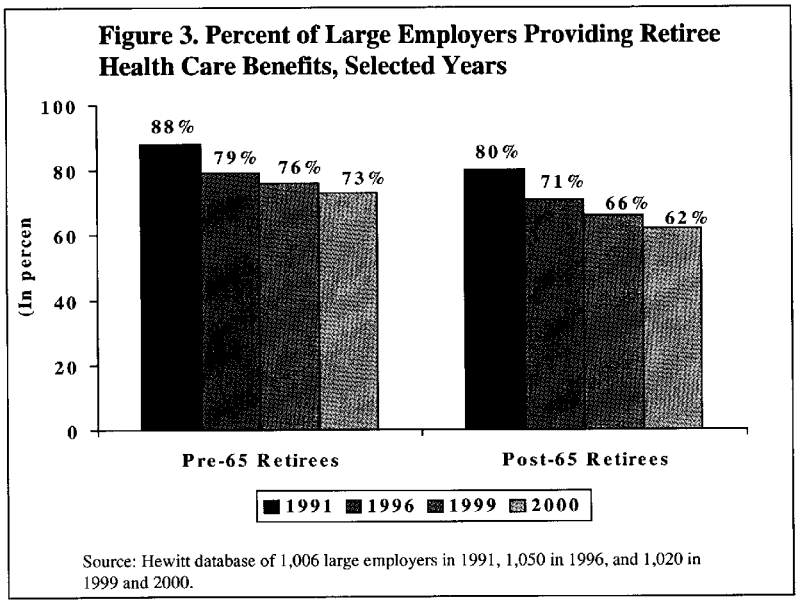
Table 1. Average Drug Expenditures Per Person for Medicare Beneficiaries, By Type of Supplementary Drug Insurance.

Source of Coverage	Total Drug Expenditure	Percentage Out-of-Pocket
Employer-Sponsored	$1,072	29%
Medicare+Choice	$682	40%
Medigap	$947	58%

Source: Medicare Current Beneficiary Survey, 1998.

Employer Sponsorship is Declining

The prevalence of retiree health coverage has declined in recent years, with some employers dropping coverage and few newer employers adding retiree health coverage. In the Hewitt large employer database, there was an 18-percentage point drop in the proportion of large employers offering retiree health coverage to age 65+ retirees between 1991 and 2000 (Figure 3).



However, the decline in the share of large companies that sponsor retiree health coverage is not solely attributable to employers dropping retiree health coverage. The decline also reflects turnover among employers in the database and the addition of newer and smaller-size employers without retiree coverage, often in high-tech or other industries in which retiree health care has little appeal to a predominantly young workforce with short tenure.

In the vast majority of cases where large employers terminated retiree health coverage, the change was made on a prospective basis, for future retirees. Thus, current retirees and those close to retirement (if not all employees) are usually "grandfathered" into the current program. Also, the elimination of retiree medical coverage may often be accompanied by increases in retirement or other benefits.

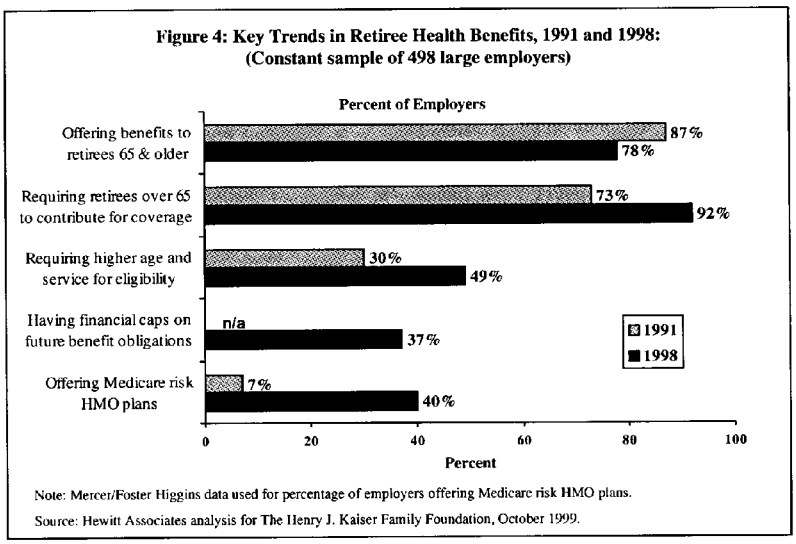
Retiree Coverage Tightening

Hewitt analyzed trends in the retiree health benefits offered by a constant sample of employers in the Hewitt database between 1991–1998.[9] For the constant sample of 498 employers, several trends in retiree health benefits emerged (Figure 4):

- Fewer employers offer post-retirement health benefits,[10]
- Employers require retirees to contribute for health benefits,
- Financial caps are often placed on employers' future obligations,
- Eligibility for benefits narrowed, and
- More employers offer Medicare managed care plans.

[9] Hewitt Associates, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits*, October 1999.

[10] The percentage of employers offering retiree health benefits is higher in the constant sample than in the overall Hewitt database because the constant sample contains a higher percentage of large employers than the full database, and large employers are more likely to offer retiree health benefits. Also, the constant sample represents the experience of more mature, stable companies.



Drug Benefit Consuming Retiree Health Benefit

The cost of the prescription drug benefit for employers has been growing more rapidly than other health expenditures and is projected to continue to rise in double-digit rates for the short-term, with at least 15 percent annual trend expected from now until 2003. Prescription drug benefits represent a significant portion—40 to 60 percent—of the total cost of the retiree health care benefit after accounting for Medicare. Furthermore, Hewitt projects that drug expenditures will represent as much as 80 percent of retiree health costs in 2003. In comparison, prescription drugs comprise approximately 15 percent of total health care costs for active employees.

As noted previously, Hewitt estimates that absent any changes in law and assuming the continuation of current coverage, employers will spend in the aggregate $22.5 billion on prescription drugs for the age 65+ retirees in 2003, increasing to $37.1 billion in 2009.

Employer Coordination with Medicare Fee-for-Service

Employers offering retiree health coverage use one of three methods to integrate their indemnity plan coverage with Medicare coverage of the same claim when Medicare is the primary payer. Employers could coordinate with a new Medicare drug benefit for fee-for-service beneficiaries in following the same techniques they currently use to integrate with fee-for-service Medicare:

1. Full Coordination of Benefits (Full COB)—The plan pays all eligible charges in excess of the Medicare reimbursement amount, or the amount it would have paid in the absence of Medicare, if less.
2. Exclusion—The plan applies its normal reimbursement formula to the eligible charges remaining after Medicare reimbursements have been deducted from total eligible charges.
3. Carve-Out—Medicare reimbursements are deducted from plan payments (which are calculated using the normal reimbursement formula and without regard to Medicare).

The method of integrating with Medicare has significant effects on the amount the employer plan pays in addition to Medicare, as well as on the retiree out-of-pocket cost for the same claim.

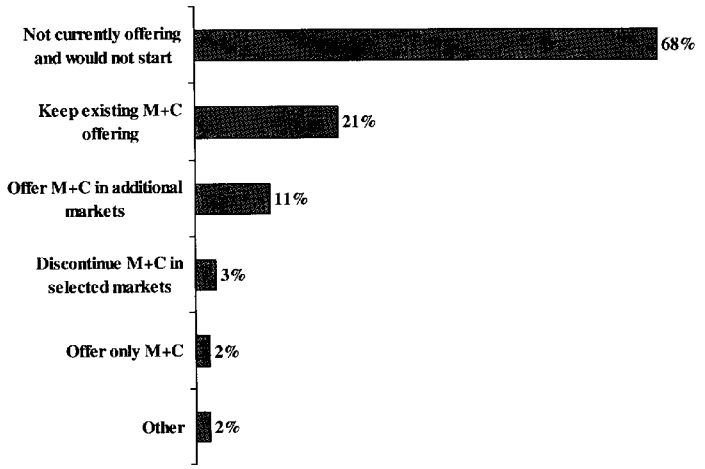
Employer-sponsored retiree coverage has shifted in recent years toward use of the carve-out approach. In 2000, 5 percent used a COB approach, 28 percent used the exclusion approach, and 57 percent used a carve-out approach, while the remaining 10 percent used some other approach (e.g., the integration varies depending on the health plan option selected by the retiree), according to the Hewitt database.

Employer Coordination with Medicare+Choice (M+C)

Employers could coordinate with a new Medicare drug benefit following the same techniques they currently use to integrate with Medicare+Choice (M+C) plans. Under M+C, retirees agree to obtain all Medicare-covered services from the M+C plan they join. This also occurs when an employer sponsors a M+C plan for retirees. Employers usually coordinate with M+C plans by negotiating with the health plan for any additional benefits and services for their retiree group and the corresponding premiums for the supplemental benefits. For example, employers usually negotiate for unlimited prescription drug coverage for their retirees, who would then receive the drug benefit through the M+C plan. The employer typically contributes a flat dollar amount per month toward the premium for the supplemental benefits.

However, while the M+C program originally seemed promising to employers, lower than expected health plan participation has made the M+C program less appealing than employers originally had hoped. For example, 68 percent of large employers indicate they do not currently offer M+C plans and do intend to offer them in the future (Figure 5).

Figure 5: Strategies for M+C 2001-2003



Note: Multiple responses possible.
Source: Hewitt Associates, *Health Care Expectations: Future Strategy and Direction 2001.*

Future Changes in Retiree Health Benefits

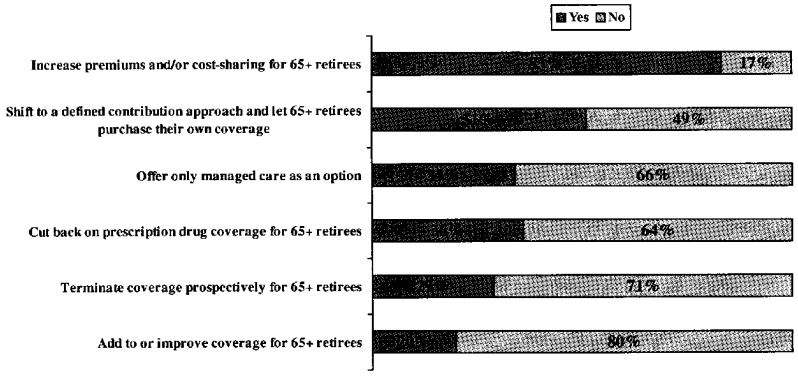
A Hewitt survey of large employers provides insight into employer strategies on their retiree health benefits.[11] The survey indicates that large employers would "seriously consider" making significant changes in retiree health plans over the next three to five years, including placing limits on existing coverage and controlling costs (Figure 6).

- Eighty-three percent of respondents said they would consider increasing premiums and cost-sharing for 65+ retirees.
- Just over half of the respondents, 51 percent, would consider shifting to a defined contribution approach and allowing age 65+ retirees to purchase their own coverage.
- Thirty-four percent of employers said they would consider only offering a managed care plan as an option.
- Thirty-six percent of employers said they would consider cutting back on prescription drug coverage for 65+ retirees.

[11] Hewitt Associates, *Health Care Expectations: Future Strategy and Direction, 2001.* The survey was conducted in September/October 2000. Survey participants included over 600 large companies (more than 1,000 employees).

- Twenty-nine percent of employers would consider prospectively terminating 65+ coverage.
- Twenty percent of respondents report they would consider adding to or improving coverage for retirees.

Figure 6: Percent of Large Employers Who Say They Would Seriously Consider Selected Changes to Retiree Medical Coverage in the Next Three to Five Years



Source: Hewitt Associates, *Health Care Expectations: Future Strategy and Direction, 2001*.

MEDICARE PRESCRIPTION DRUG BENEFIT PROPOSALS

In recent years, many proposals have been developed to provide outpatient prescription drug coverage to Medicare beneficiaries. Several of the primary proposals would add prescription drugs to the Medicare program as a covered benefit. The prescription drug benefit would be available to all beneficiaries (universal) on a voluntary basis. The design of a Medicare drug benefit and its rules related to retiree coverage would determine the likely effect on employers and retirees. This section of the testimony will discuss the probable impact a new Medicare drug benefit would have on employers and retirees.

Forecasting and discussing the effects of a Medicare drug benefit on employer-sponsored retiree health plans and retirees is difficult, especially without ascertaining the specific benefit levels that the drug benefit would provide. Other key information relates to how the benefit would be delivered to retirees, the subsidy levels (if any) provided to retirees and employers, and the coordination rules concerning employer-sponsored plans.

Employer Response Options

In response to the creation of a Medicare prescription drug benefit, employers would have several possible options for their retiree health benefits. Hewitt has modeled the potential impact a new Medicare drug benefit may have on employers and retirees based on five potential employer options.[12] The response undertaken by employers and the specific details of the Medicare drug benefit will determine the impact on employers and retirees.

These five employer responses are based on a Hewitt survey of approximately 327 large employers (1,000+ employees) in 1999, which asked for employers' likely responses to the Clinton Administration's Medicare drug plan.[13] The responses serve as a proxy for how employers are likely to react to a new Medicare drug benefit.

[12] The five estimated employer response options to a Medicare drug benefit are: (1) retain retiree prescription drug coverage and accept the employer subsidy (if offered), (2) retain retiree drug coverage and coordinate with the new drug program, (3) retain retiree drug coverage, coordinate with the new drug program and pay for the retiree drug premium, (4) eliminate retiree drug coverage, and (5) eliminate retiree drug coverage and pay for the retiree drug premium.

[13] Hewitt Associates, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits*, October 1999.

The survey asked employers to select from a list of options regarding how they would most likely react if the Administration's drug proposal were enacted.

- Eighty percent of employers would retain their prescription drug coverage.

—Fifty-five percent would retain prescription drug coverage as a supplement to the Medicare benefit, of which two percent would also pay for the retiree's added Medicare premium.

—Twenty-five percent would retain primary prescription drug coverage and accept the subsidy from Medicare.

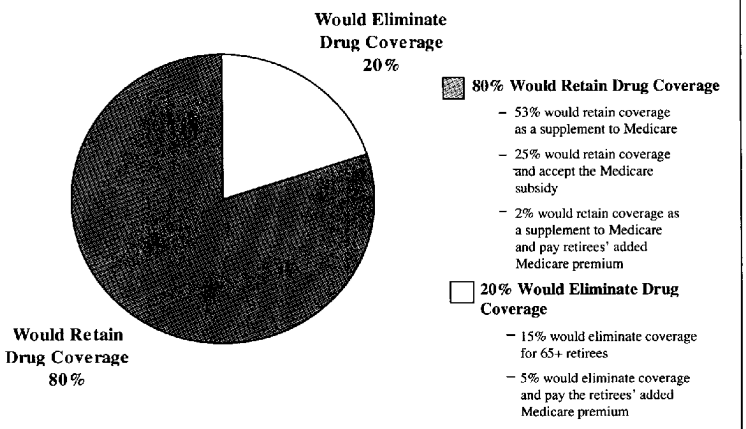
- Twenty percent of employers would eliminate prescription drug coverage for age 65+ retirees.

—Fifteen percent would eliminate prescription drug coverage for 65+ retirees.

—Five percent would eliminate prescription drug coverage and pay for the retiree's added Medicare premium.

The key finding is that eighty percent of respondents said they would most likely retain, and not eliminate, drug coverage for retirees. The majority would wrap their drug coverage around the Medicare drug benefit and achieve financial relief for drug expenditures as a result (Figure 7).

Figure 7: How Large Employers Say They Would Be Most Likely to Respond to the Administration's Medicare Drug Benefit Proposal



Source: Hewitt Associates, *Health Care Expectations: Future Strategy and Direction*, October 1999.

Impact on Employers

Depending on the design of the new Medicare drug program and benefits provided, employers could potentially experience some relief from rising prescription drug costs for retirees. Without financial relief from growing retiree health costs, coverage would most likely continue to erode at a more rapid rate than if there were Medicare-supported prescription drug coverage. The majority of employers with retiree health benefits would continue to offer prescription drug coverage to retirees and experience some easing of cost pressure from prescription drugs. The preferred employer strategy would be to wrap-around (coordinate with) the universal Medicare benefit and the retiree drug benefit.

After accounting for proposed Medicare drug benefits, employers would still spend approximately 71–77 percent of their current total per retiree cost in 2003 for Medicare-eligible retiree drug benefits when wrapping-around a proposed drug benefit, and employer spending would be even higher if they pay all or part of any retiree premium required for the Medicare drug benefit. Employers would achieve limited financial relief because the proposed Medicare drug coverage represents a minority portion of the more generous employer-sponsored retiree coverage. Conversely, if a $4,000 federal stop-loss provision is added that would somewhat reduce employer spending, but even then employers would still be spending approximately 66 percent of the total drug cost per retiree in 2003.

The design of the new Medicare drug program and how it allows employers to coordinate retiree coverage with the Medicare drug benefit is critical in determining the impact on employers. The new Medicare drug program could encourage employers to offer retiree health coverage by allowing employers to wrap-around the Medicare drug benefit. The specific details of the Medicare drug benefit should require the least amount of administrative complexity and expense. Prohibiting employers from wrapping-around the Medicare drug benefit could further the decline in employer-sponsored retiree health care. Although a direct subsidy for employers to offer retiree drug benefits is designed to encourage employers to offer drug coverage and would lower employer costs for retiree drug benefits, most employers would prefer to forego the direct subsidy and instead wrap-around the Medicare drug benefit.

Programs targeting low-income individuals, by their design, would offer little or no financial savings to employers. Low-income proposals would not have a significant impact on retirees with employer-sponsored health benefits because most of these retirees would not qualify for coverage. The majority of these retirees would have incomes well above the poverty level from a combination of higher benefits from Social Security and from employer-sponsored pension and savings plans.

Impact on Retirees

The potential impact of a new Medicare drug benefit on retirees depends on the design of the Medicare drug program and employers' response to the new benefit. Retiree out-of-pocket costs would be dependent on the subsidy level in the Medicare program. As the subsidy levels increase under Medicare, retirees' costs would decrease.

Employer reactions to the Medicare drug benefit and any subsequent modifications to employer-sponsored retiree health benefits would impact retirees. Retirees would maintain their current generous coverage levels if employers continued their retiree health benefits and wrapped-around the new Medicare drug benefit. The manner in which employers wrapped-around the new Medicare drug benefit would affect retirees' out-of-pocket costs, depending on whether employers paid for all or part of the retiree premiums for the new Medicare drug benefit.

Conclusion

In the short-term, the creation of a Medicare prescription drug benefit could slow (but probably not reverse) the erosion of retiree health care coverage among large employers because it could provide financial relief from rising retiree health costs. Hewitt estimates that the majority of employers with retiree health care benefits would maintain coverage by wrapping-around the Medicare drug benefit. Even though a new Medicare drug benefit would not immediately lead to the elimination of retiree drug coverage, it could encourage a gradual decline over the long-term, as retiree health care costs have been increasing for employers at double-digit rates and are a major source of concern.

Medicare drug coverage only represents one important consideration, as employers review their options regarding retiree health benefits. So longer-term, there is considerable uncertainty about how employers would make decisions regarding their retiree health programs. For example, economic and legal considerations would also be very important, as well as the employer's competitive position in a global economy. Such factors may lead to a continued gradual decline over the long-term. For that reason, the Committee may wish to consider other ways of encouraging retiree health programs. In a previous report,[14] we outlined several technical possibilities, such as using surplus pension assets to fund retiree medical expenses for the same group of employees in the pension plan and making minor changes to the tax code, and there are others as well that merit review.

In closing, Medicare prescription drug coverage proposals must address the complex issues regarding interactions with employer-sponsored retiree health benefits, which are the largest source of drug coverage for Medicare beneficiaries. Policymakers should carefully consider the inter-relationships and incentives between a Medicare drug benefit and employer-sponsored retiree health care. The Senate Finance Committee is to be commended for conducting this hearing.

PREPARED STATEMENT OF DAN L. CRIPPEN

Mr. Chairman and Members of the Committee, I am pleased to be here today to describe the Congressional Budget Office's (CBO's) latest projections of Medicare

[14] Hewitt Associates, *The Implications of Medicare Prescription Drug Proposals for Employers and Retirees*, prepared for the Henry J. Kaiser Family Foundation, July 2000.

spending and their implications for the program in the long run. I will also raise several issues to be considered in designing an outpatient prescription drug benefit for Medicare beneficiaries. Those two topics are related: while the financial pressure faced by Medicare in the next decade and beyond has intensified interest in restructuring the program, that same pressure complicates efforts to expand Medicare to add a new benefit that could be very costly.

PROJECTIONS OF MEDICARE SPENDING UNDER CURRENT LAW

The growth of Medicare spending has been much slower in the past few years than it has been historically. In fiscal years 1998 through 2001, CBO estimates that benefit payments will have grown at an average annual rate of 3.4 percent, compared with 10.0 percent per year over the previous decade. That lower rate of growth can be attributed to several factors, including the Balanced Budget Act of 1997 (BBA), strong efforts to reduce fraud and abuse by increasing compliance with payment rules, and slower inflation, both economy-wide and in the health care sector.

Partly in response to the slowdown in Medicare spending, the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA) increased payments to providers and plans above the levels that would otherwise have resulted. Those increases will continue to be felt in future years.

CBO estimates that Medicare will spend $237 billion on benefits for 40 million elderly and disabled people in fiscal year 2001. Despite the recent slowdown in spending growth, that amount is almost 25 percent more than Medicare spent five years ago. Medicare now accounts for about 12 percent of estimated total federal spending, or 2.3 percent of gross domestic product (GDP).

Moreover, CBO is projecting faster Medicare growth over the next decade. We estimate that Medicare spending will more than double reaching $491 billion by fiscal year 2011, reflecting an average increase of 7.7 percent per year (see Figure 1). At that rate, Medicare spending in 2011 will constitute 19 percent of the federal budget, assuming no change occurs in current tax and spending policies. In fact, the program will account for 36 percent of the projected increase in federal spending by the end of the decade.

CBO expects the growth in Medicare spending to accelerate for several reasons. The bulk of the savings from the compliance efforts that were begun in the late 1990s have now been realized. In addition, provider payment rates for most services (including hospital care and services furnished by physicians, skilled nursing facilities, and home health agencies) are automatically increased to reflect changes in input prices. CBO estimates that those updates will raise Medicare spending by 3.1 percent annually over the next decade, as a result of recent legislation boosting some rates and the expiration of previous legislation restricting others. Roughly 43 percent of the projected increase in Medicare spending in fiscal years 2002 through 2011 comes from automatic updates and other changes in payment rates.

Increases in the utilization of health services resulting from a larger and older Medicare population make up an additional 26 percent of the projected increase in program spending. The number of Medicare beneficiaries will rise over the next 10 years and the average age of Medicare beneficiaries will increase as people live longer. As a result, Medicare beneficiaries will use more services. The remaining 31 percent of the projected spending increase is attributable to other factors, such as changes in medical technology and practice patterns as well as changes required by the BBA, BBRA, and BIPA (for example, expansions in covered benefits).

As with all CBO projections, these figures are not intended to predict the future. As baseline estimates, they explicitly assume no legislative changes during the period to which they apply. Nevertheless, they illustrate the mounting financial pressure facing the Medicare program under current and expected future conditions.

LONG-TERM PROJECTIONS

Medicare spending occurs under two separate programs, the Hospital Insurance (HI) program, or Part A, and the Supplementary Medical Insurance (SMI) program, or Part B. HI spending will total an estimated $137 billion in fiscal year 2001, paying for inpatient hospital care, some stays in skilled nursing facilities, some home health care, and hospice services. SMI spending in that year is projected to reach almost $100 billion, paying for services from physicians and outpatient care facilities, as well as medical supplies and home health benefits.

The HI program is financed by the Medicare payroll tax and the portion of income taxes on Social Security benefits that is earmarked for the HI trust fund. The SMI program is financed primarily from general revenues that cover about 75 percent

of SMI costs, with the rest covered by monthly premiums paid by enrollees. It should be noted that 87 percent of total Medicare revenues in 2001 come from taxes paid by current workers; current Medicare beneficiaries pay the other 13 percent through SMI premiums and income taxes on Social Security benefits.

The annual report released earlier this week by the Medicare Board of Trustees indicates that estimated total income to the HI trust fund will exceed estimated outlays by $29.8 billion in fiscal year 2001. But $12.6 billion of that amount comes from interest on the trust fund's assets and from other miscellaneous sources. If just the tax revenues dedicated to the HI trust fund were counted against the fund's outlays, its estimated surplus this year would be only $17.2 billion.

The Medicare trustees also report that under their intermediate assumptions, the HI trust fund will exhaust its assets in 2029 four years later than they projected in last year's report. But the trust fund's expenses will exceed its dedicated revenues beginning in 2016 a full 13 years earlier. By 2029, the revenues dedicated to the HI trust fund would equal only 68 percent of costs; by 2075, that ratio would be only 32 percent.

Those data do not take into account Medicare's SMI program, which is growing more rapidly than the HI program. As recently as fiscal year 1997, HI benefit payments constituted 66 percent of total Medicare benefit payments. As of 2001, that proportion had declined to 58 percent, and CBO projects that it will have declined to 53 percent by fiscal year 2011. Some of that change is due to the movement of home health care from HI to SMI according to the provisions of the BBA, which increases the estimated balance in the HI trust fund in fiscal year 2011 by about $240 billion. That shift further blurs an already hazy distinction between the two programs.

The Medicare trustees' report projects that total Medicare spending will increase from 2.2 percent of GDP in 2000 to 3.9 percent in 2025 and 8.5 percent in 2075. Those numbers reflect a change in the trustees' assumptions from last year, following the recommendation of their panel of experts that they raise their projection of long-term growth in Medicare spending per beneficiary.[1]

The mounting financial pressure on the Medicare program is highlighted by the large and growing difference between projected total Medicare spending and the total amount of federal revenues specifically dedicated to the program, including the Medicare payroll tax, the portion of the income taxes on Social Security benefits that are paid to the HI trust fund, and premiums paid by enrollees for SMI. That difference is the minimum amount of federal general revenues required to fund total Medicare expenditures.

According to the Medicare trustees, the discrepancy between total Medicare expenditures and dedicated revenues will be $64.0 billion in 2001, or 0.6 percent of GDP (see Figure 2). By 2011, that gap is projected to rise to $138.6 billion, or 0.8 percent of GDP. That amount would represent 30 percent of Medicare's gross outlays, up from 26 percent in 2001. By 2075, that gap is projected to grow to 6.0 percent of GDP.

Beyond the next decade, utilization of Medicare-covered services is expected to accelerate. As I stated earlier, Medicare enrollment, which has increased at a rate of about 1 percent a year over the past 10 years and is expected to grow somewhat faster over the next decade, will rise even more rapidly as the baby-boom generation begins to retire in 2011. According to the Medicare trustees, there will be 77 million beneficiaries in 2030 an increase of 95 percent over this year's enrollment. In addition, as technology advances, more services will be available for use by more patients, and those services will be more costly.

At the same time, the number of workers whose payroll taxes provide the bulk of Medicare's dedicated revenues will not keep up with the growing number of beneficiaries. While the number of beneficiaries in 2030 will be 95 percent greater than it is now, the number of workers paying into Medicare will be only about 15 percent greater. As a result, the ratio of covered workers to Medicare beneficiaries is expected to fall from 4.0 to 2.3. Correspondingly, Medicare HI spending as a percentage of taxable payroll is expected to rise, from 2.7 percent in 2000 to 4.9 percent in 2030 and 10.7 percent by 2075 (see Figure 3).

These financial pressures have focused policymakers' attention on restructuring the Medicare program. There are two basic issues. First, Medicare lacks a mechanism for using market forces to encourage efficiency in running the program and providing health care to its beneficiaries. Although the Medicare+Choice program was intended to expand the availability of different types of private plans to Medicare beneficiaries and increase the use of private-sector approaches for organizing

[1] That change is consistent with the one that CBO applied in its most recent report (October 2000) on *The Long-Term Budget Outlook*.

and delivering health care, price competition among such plans is limited to the premium they charge for additional benefits and the amount of cost sharing faced by their enrollees.[2] Moreover, plan participation has declined, resulting in reduced enrollment, and attempts to develop competitive-bidding demonstration projects in selected areas have not been successful.

Second, Medicare does not provide modern insurance protection to its beneficiaries. Its benefits are still modeled largely on those provided by the private insurance industry of the 1960s. And unlike typical private coverage today, it does not cover outpatient prescription drugs. In addition, some Medicare benefits are subject to coverage limits, and the program has no stop-loss provision to protect beneficiaries against the consequences of very costly episodes of illness that may exceed those limits. As a result, many elderly people have purchased additional coverage through medigap policies, and others rely on employer-sponsored coverage to reduce their financial risk.

PROVIDING COVERAGE FOR PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

Beneficiaries' Current Spending on Prescription Drugs

In recent years, growth in prescription drug spending has far outpaced growth in spending for other types of health care. The impact of those rising expenditures on Medicare beneficiaries, on employers who offer retiree health coverage, and on state governments has, in turn, put proposals for a prescription drug benefit through Medicare near the top of the policy agenda.

Between 1990 and 2000, annual spending on prescription drugs in the United States grew at nearly twice the rate as that for total national health expenditures, and it has maintained a double-digit pace since the mid-1990s. For the U.S. population as a whole, three factors explain most of that growth: the introduction of new and costlier drug treatments, broader use of prescription drugs by a larger number of people, and lower cost-sharing requirements by private health plans. Within some therapeutic classes, new brand-name drugs tend to be much costlier than older drug therapies, which has also contributed to growth in spending. Use of prescription drugs has broadened as well, because many new drugs provide better treatment or have fewer side effects than older alternatives and more people are aware of new drug therapies through the "direct to consumer" advertising campaigns of pharmaceutical manufacturers.

Even without a Medicare drug benefit, CBO expects prescription drug costs for Medicare enrollees to grow at a rapid pace over the next decade (see Table 1). At an average annual rate of 10.3 percent per beneficiary, drug costs would rise at nearly twice the pace of combined costs for Medicare's HI and SMI programs, and much faster than growth in the nation's economy. (CBO's estimates of rising drug spending are based on the latest projections for prescription drug costs within the national health accounts.)

Existing Coverage

Third-party coverage for prescription drugs has become more generous for the population as a whole, but that trend is less clear for Medicare beneficiaries. In 1997, nearly one-third of the Medicare population had no prescription drug coverage. On average, Medicare beneficiaries paid about 45 percent of their drug expenditures out of pocket (see Figure 4). By comparison, all people in the United States paid an average of 39 percent of the cost of their prescriptions. Because Medicare beneficiaries are elderly or disabled, they are also more likely to have chronic health conditions and use more prescription drugs: nearly 89 percent filled at least one prescription in 1997. Medicare beneficiaries made up 14 percent of the population that year, yet they accounted for about 40 percent of the $75 billion spent on prescription drugs in the United States.

Those factors suggest that growth in drug spending has a larger financial impact on the Medicare population than on other population groups. However, aggregate statistics mask a wide variety of personal circumstances. Nearly 70 percent of beneficiaries obtain drug coverage as part of a plan that supplements Medicare's benefits, but those supplemental plans vary significantly in their generosity.

Traditionally, retiree health plans have provided prescription drug coverage to more seniors than any other source, and their benefits have been relatively generous. In 1997, about one-third of Medicare beneficiaries had supplemental coverage through a current or former employer, and most of those plans provided drug coverage (see Table 2). Although specific benefits vary, it is common to find relatively low deductibles and copayments in employer-sponsored drug plans.

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[2] Beginning in 2003, plans can offer their enrollees rebates on a portion of the SMI premium.

However, prescription drug spending by elderly retirees has become a significant cost to employers, and many have begun to restructure their benefits. For example, a 1997 Hewitt Associates' study for the Kaiser Family Foundation found that among large employers, drug spending for people age 65 or older made up 40 percent to 60 percent of the total cost of their retiree health plans. Average utilization of prescription drugs among elderly retirees was more than double that for active workers. Although relatively few employers in the Hewitt survey have dropped retiree coverage altogether, most have taken steps to control costs, such as tightening eligibility standards, requiring retirees to contribute more toward premiums, placing caps on the amount of benefits that plans will cover, and encouraging elderly beneficiaries to enroll in managed care plans.

In some parts of the country, Medicare+Choice (M+C) plans are another means by which the elderly and disabled have obtained prescription drug coverage. In 2000, for example, 64 percent of Medicare beneficiaries had access to M+C plans that offered some drug coverage. However, many M+C plans have scaled back their drug benefits in response to rising costs and slower growth in Medicare's payment rates. Nearly all such plans have annual caps on drug benefits for enrollees many at a level of only $500 per year and a growing share of plans charge a premium for supplemental benefits.

While 26 percent of the Medicare population relied on individually purchased (often medigap) plans as their sole form of supplemental coverage in 1997, less than half of that group had policies that covered prescription drugs. Medigap plans with drug coverage tend to be much less generous than retiree health plans; medigap plans have a deductible of $250, 50 percent coinsurance, and annual benefit limits of either $1,250 or $3,000. Premiums for plans that include drug coverage also tend to be much higher than premiums for other medigap plans, due in part to their tendency to attract enrollees who have higher-than-average health expenses.

Certain low-income Medicare beneficiaries may be eligible for Medicaid coverage, which generally includes a prescription drug benefit. All state Medicaid programs offer prescription drug coverage (usually involving little or no cost sharing) to people whose income and assets fall below certain thresholds. In addition, as of January 2001, 26 states had authorized (but had not necessarily yet implemented) some type of pharmaceutical assistance program, most of which would provide direct aid for purchases to low-income seniors who did not meet the Medicaid requirements. About 64 percent of the Medicare population lives in those states.

Thus, middle- and higher-income seniors can usually obtain coverage through retiree or M+C plans, while seniors with the lowest income generally have access to state-based drug benefit programs. However, beneficiaries with incomes between one and two times the poverty level are more likely to be caught in the middle, with income or asset levels that are too high to qualify for state programs and less access than higher-income enrollees to drug coverage through former employers.

Design Choices for a Medicare Drug Benefit

Rapid growth in prescription drug costs, together with erosion of private insurance coverage for retirees, suggests that there will be continued political pressure for relief to seniors and the disabled through the Medicare program. Depending on the structure of the proposed benefit, though, those same forces could also rapidly expand the cost of a new Medicare drug program because individuals tend to consume more or costlier prescription drugs when they obtain insurance coverage. Further, implementing only a drug benefit now might complicate more extensive reform of the Medicare program in the future.

A Medicare drug benefit might address a number of objectives. The most fundamental would be to ensure that all beneficiaries had access to reasonable coverage for outpatient prescription drug costs but there is room for considerable debate about what that would mean. The various objectives that might be thought desirable in the abstract are often mutually incompatible, so that difficult choices must be made. For example, it is not possible to provide a generous drug benefit to all Medicare beneficiaries at low cost either enrollees' premiums or the government's subsidy costs would be high. If most of the costs were paid by enrollees' premiums to keep federal costs low, some Medicare beneficiaries would be unwilling or unable to participate in the program. If costs were limited by covering only catastrophic expenses, few enrollees would benefit in any given year, possibly reducing support for the program. If, instead, costs were limited by capping the annual benefits paid to each enrollee, the program would fail to protect participants from the impact of catastrophic expenses.

In designing a drug benefit, policymakers must make four fundamental decisions:

- Who may participate?
- How will program costs be financed?

- How comprehensive will coverage be?
- Who will administer the benefit and under what conditions?

Participation. Although most Medicare enrollees use some prescription drugs, the bulk of such spending is concentrated among a much smaller group. In 1997, about 13 percent of enrollees had expenditures of $2,000 or more, accounting for 45 percent of total drug spending by the Medicare population. Forty-six percent had expenditures of $500 or less, making up about 8 percent of total spending. Most spending is associated with treatment of chronic conditions such as hypertension, cardiovascular disease, and diabetes. The skewed distribution of spending and the need for people with chronic conditions to stay on drug therapies over the long term makes stand-alone drug coverage particularly susceptible to adverse selection, where enrollment is concentrated among those who expect to receive more in benefits than they would pay in premiums.

Because of the likelihood of adverse selection, a premium-financed drug benefit offered as a voluntary option for Medicare enrollees must restrict participation in some way. If Medicare beneficiaries were free to enroll in or leave the program at will, only those who expected to gain from the benefit would participate each year. That would drive premiums up, which would further reduce enrollment as those enrollees with below-average drug costs dropped out.

Most of the drug benefit proposals developed in 2000 would have provided a voluntary drug option, but they attempted to mitigate the potential for adverse selection by one of two approaches: either they gave enrollees only one opportunity to choose the drug benefit, at the time they first became eligible, or they imposed an actuarially fair premium surcharge on those who delayed enrollment. Another approach that would avoid the problem of adverse selection would be to couple the drug benefit with Part B of Medicare, so that enrollees could choose either Part B plus a drug benefit or no Part B and no drug benefit. In that case, even if the drug portion of the benefit was not heavily subsidized, the current 75 percent subsidy of Part B benefits would ensure nearly universal participation in the coupled benefit.

Financing. Program costs could be entirely financed by enrollees' premiums, or some or all of the costs could be paid by the federal government. Given a one-time-only enrollment option, participation rates would be reasonably high, even if the program was largely financed by enrollees' premiums. If enrollees lived long enough, virtually all of them would benefit from drug coverage, and the erosion now occurring in the comprehensive coverage provided by private plans would also spur participation. Further, employer-sponsored health plans would probably require that retirees eligible for a new Medicare benefit participate in it, just as they now effectively require that retirees participate in Part B. And state Medicaid agencies, even if not required to do so, would choose to enroll dual eligibles (people eligible for both Medicare and Medicaid) in a new Medicare drug benefit if their costs under the new program were less than the cost of the drug benefits now provided under Medicaid. However, if a generous drug benefit was fully financed by enrollees, premiums would be high, making the benefit difficult to afford for lower-income beneficiaries ineligible for Medicaid. The drug proposals developed last year all provided full subsidies to low-income people for both cost-sharing and premium expenses, in addition to partially subsidizing premium costs for all other enrollees.

Coverage. A Medicare drug benefit could be designed to look like the benefit typically provided by employer-sponsored plans. If so, it would be integrated with the rest of the Medicare benefit. Further, it would have low cost-sharing requirements (ranging from 20 percent to 25 percent coinsurance or a copayment per prescription of $10 to $25) and stop-loss protection a dollar limit above which no cost sharing would be required. Such comprehensive coverage would provide good protection for enrollees, but it would be very costly. Not only would it transfer most of the costs of drugs currently used by enrollees to the Medicare program, but it would also increase utilization among those with less generous coverage now.

One way to constrain costs and utilization is by limiting coverage covering only catastrophic costs, for example, or imposing a cap on benefits paid per enrollee each year. If Medicare provided coverage only for catastrophic costs, most enrollees would receive no benefit payments in any given year. Nevertheless, it would be inaccurate to say that those enrollees would receive no benefit, since they would be protected against the possibility of catastrophic expenses the main function of insurance. Public support for a drug benefit might be stronger, though, if most enrollees could reasonably expect to receive some benefit payments each year.

Alternatively, policymakers could take the other approach to limiting costs: covering a portion of all drug costs but only up to a benefit cap. But because that approach would not protect those enrollees who are most in need, most of last year's proposals included stop-loss protection. The end result was a benefit unlike anything available in the private sector a hybrid that had a capped benefit, then a "hole" with

no drug coverage, and finally a stop-loss provision, beyond which the program would pay all drug costs (see Figure 5). The larger the range of spending encompassed by the hole, the less costly the program would be but also the less coverage the benefit would provide.

An approach to limiting costs within the context of a more traditional benefit would be to have a higher initial deductible amount, relatively high cost-sharing requirements, and a high stop-loss value. Or the program could provide a more generous benefit similar to those provided by employer-sponsored plans, with federal costs limited by having most of the costs financed by enrollees' premiums.

Administration. The way in which a drug benefit is administered can also have a significant effect on how costly it is. All recent proposals have envisioned adopting the now common private-sector approach of using pharmacy benefit managers (PBMs) in each region. Proposals have differed, however, in whether only one or several PBMs would serve a region, in whether the responsible entities would assume any insurance risk, and in what kind of restrictions would be placed on them.

Private health plans use PBMs to process claims and to negotiate price discounts with drug manufacturers and dispensing pharmacies. PBMs also try to steer beneficiaries toward lower-cost drugs, such as generic, preferred formulary, or mail-order drugs. In addition, because of their centralized records for each enrollee's prescriptions, they can help to prevent adverse drug interactions. The likelihood that PBMs could effectively constrain costs depends on their having both the authority and the incentive to aggressively use the various cost-control mechanisms at their disposal. In the private sector, PBMs often have considerable leeway in the tools they can use, but they do not assume any insurance risk for the drug benefit. At most, they may be subject to a bonus or a penalty added to their administrative fee, based on how well they meet prespecified goals for their performance.

Some of the proposals developed last year (such as the one developed by the Clinton Administration) adopted the typical private-sector model, with a single PBM selected periodically to serve each region and with all insurance risk borne by Medicare, not the PBM. Two main concerns about that model are that it might prove politically difficult to allow the designated PBMs to use cost-control tools aggressively if enrollees have no choice of provider in each region, and that non-risk-bearing PBMs might have too little incentive to use strong tools, even if they were permitted.

Other proposals (such as the Breaux-Frist bills and the House-passed drug bill) adopted a different model, more akin to the risk-based competitive model characteristic of Medicare+Choice plans. Those proposals envision multiple risk-bearing entities (such as PBM/insurer partners) that would compete to serve enrollees in each region. Enrollees would have some choice among providers, so that beneficiaries who were willing to accept more-restrictive rules (such as a closed formulary) in return for lower premium costs could do so, while others could select a more expensive provider with fewer restrictions. If the entities bore all of the insurance risk for the drug benefit, they would have strong incentives to use whatever cost-control tools were permitted. However, they would also have strong incentives to try to achieve favorable selection by avoiding enrollees most in need of coverage.

One concern about this model was that no entities might be willing to participate if they had to assume the full insurance risk for a stand-alone drug benefit. To mitigate that concern, the proposals included federally provided reinsurance for high-cost enrollees. (Reinsurance means that the federal government would share part or all of the costs of high-cost enrollees.) However, reinsurance would tend to weaken the plans' incentives to control costs. Another concern was that differences among plans in benefit structures or strategies for cost control could result in some plans attracting low-cost enrollees and others attracting sicklier and more costly enrollees. The risk of that kind of selection would lead plans to raise the cost of the benefit. Moreover, to avoid such risks, plans would, over time, come to offer very similar plan designs.

The Cost of Covering Prescription Drugs for Medicare Enrollees

CBO is in the process of updating its estimates for several of the proposals developed in the last session of the 106th Congress. Some sense of the potential costs of a Medicare drug benefit can be gained, however, by adding up the amounts that Medicare enrollees are expected to spend on prescription drugs under current law (see Table 3). Over the period from 2002 through 2011, CBO estimates that about $1.5 trillion will be spent on prescription drugs for Medicare enrollees under current law. Thus, a drug benefit that covered 50 percent of enrollees' spending would cost about $728 billion through 2011. If, instead, the benefit covered all costs above $1,000 per enrollee per year, costs through 2011 would be about $1.1 trillion. If only costs above $5,000 a year were covered, costs through 2011 would be about $365

billion. Those figures, however, are only meant to give a sense of the magnitude. The costs of a drug benefit would also depend on utilization responses by enrollees, the kinds of cost-management tools that would be used, and how much of the gross costs of the benefit would be financed through enrollees' premiums.

CONCLUSIONS

Despite the recent slowdown, spending for Medicare is expected to grow at an annual rate of 7.7 percent over the next decade. After that, growth is likely to be more rapid as the leading edge of the baby-boom population becomes eligible for benefits. Although the latest report by the Medicare trustees shows improvement in the HI trust fund's balances, that fund does not give a complete picture of Medicare's financial condition in particular, it ignores the excess of costs over premium revenues for the SMI program. Because Medicare's projected spending outstrips expected growth in dedicated revenues, the program will increasingly depend on general revenues to cover its costs.

While policymakers are well aware of Medicare's long-run financial problems, they also know that its benefit package has deficiencies relative to the benefits typically provided by private-sector insurance plans. One such deficiency is that the program provides only very limited coverage for outpatient prescription drugs an increasingly important component of modern medical care. But adding a drug benefit would significantly increase Medicare's costs, and unless it was fully financed by enrollees' premiums, it would exacerbate the imbalance between the program's projected spending and its dedicated revenues.

TABLE 1. CBO'S BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING AND MEDICARE BENEFITS PER ENROLLEE, CALENDAR YEARS 2002-2011

	Spending per Enrollee (Dollars)		Average Annual Percentage Change, 2002-2011
	2002	2011	
Drug Spending[a]	1,989	4,818	10.3
Medicare Benefits[b]	6,512	10,538	5.5
Memorandum:			
Gross Domestic Product per Capita	39,275	56,569	4.1

SOURCE: Congressional Budget Office.

a. Total spending per enrollee on outpatient prescription drugs not currently covered under Medicare, regardless of payer.
b. Medicare benefits per enrollee under the Hospital Insurance and Supplementary Medical Insurance programs.

TABLE 2. PRESCRIPTION DRUG COVERAGE AMONG MEDICARE ENROLLEES BY TYPE OF SUPPLEMENTAL COVERAGE, 1997

	Number of Medicare Enrollees (Thousands)			Percentage of All Enrollees		
	No Drug Coverage	Drug Coverage	Total	No Drug Coverage	Drug Coverage	Total
No Supplemental Coverage	2,941	0	2,941	7.4	0	7.4
Any Medicaid Coverage[a]	1,448	5,449	6,897	3.6	13.7	17.4
Employer-Sponsored Plans	1,671	11,163	12,834	4.2	28.1	32.3
Individually Purchased Policies	5,753	4,532	10,286	14.5	11.4	25.9
Other Public Coverage[b]	0	1,396	1,396	0	3.5	3.5
HMOs Not Elsewhere Classified[c]	678	4,696	5,374	1.7	11.8	13.5
Total	12,491	27,236	39,728	31.4	68.6	100.0

SOURCE: Congressional Budget Office based on data from the 1997 Medicare Current Beneficiary Survey.

NOTES: Some beneficiaries hold several types of coverage at once. The categories in this table are mutually exclusive, and CBO assigned people to groups in the order shown above. The numbers in the table may not add up to totals because of rounding.

HMO = health maintenance organization.

a. Comprises beneficiaries who received any Medicaid benefits during the year, including those eligible for a state's full package of benefits as well as others who received assistance for Medicare premiums or cost sharing through the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual programs.

b. Beneficiaries who received aid for their drug spending through state-sponsored pharmacy assistance programs for low-income elderly make up 60 percent of this category. The remainder received prescription drug benefits through the Veterans Administration.

c. Primarily HMOs under Medicare+Choice risk contracts.

TABLE 3. PROJECTED SPENDING ON PRESCRIPTION DRUGS BY MEDICARE ENROLLEES (In billions of dollars)

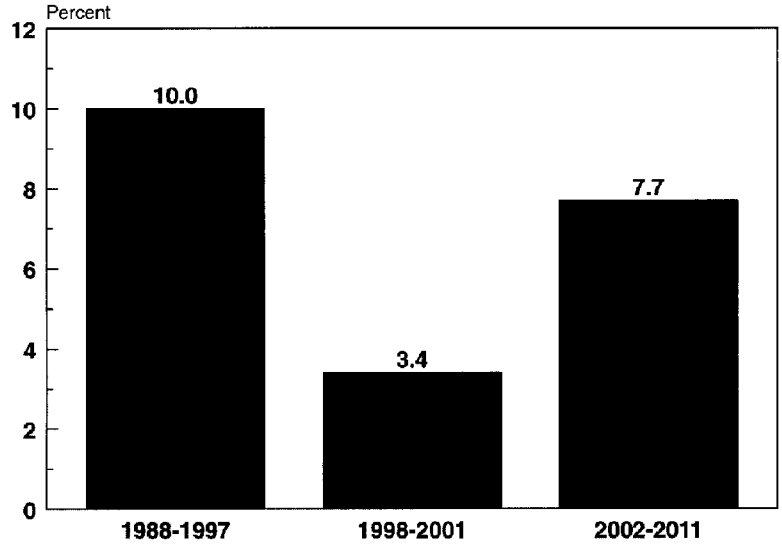
Year	All Spending per Enrollee Above					
	$0	$1,000	$2,000	$3,000	$4,000	$5,000
2002	81	49	29	18	11	8
2003	92	59	38	24	16	11
2004	104	70	47	32	22	15
2005	117	81	57	40	28	20
2006	131	95	68	50	36	27
2007	148	110	82	61	46	35
2008	165	126	97	74	57	44
2009	185	145	113	89	70	55
2010	205	164	131	105	84	68
2011	228	185	151	123	101	82
Total, 2002-2011	1,456	1,084	814	616	472	365

SOURCE: Congressional Budget Office (using its January 2001 baseline).

NOTES: Drugs currently covered by Medicare are not included in these figures.

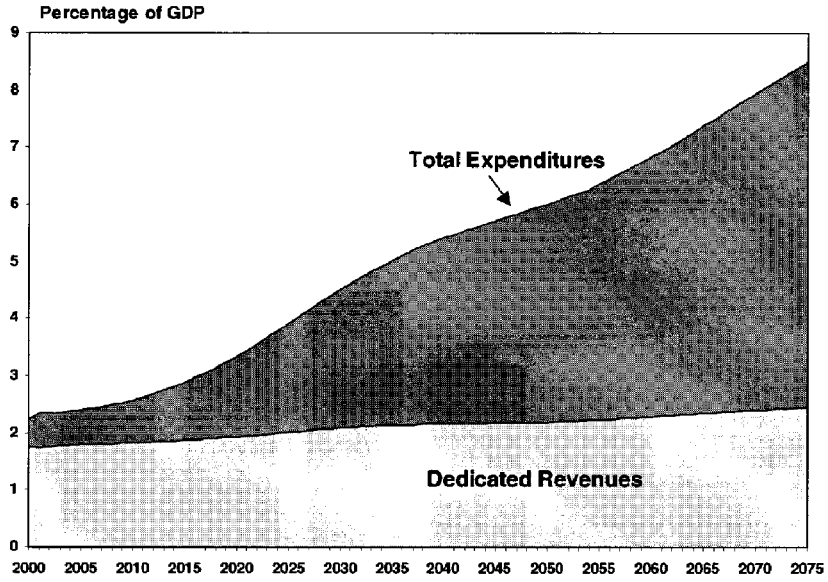
The numbers in the table may not add up to totals because of rounding.

FIGURE 1. ANNUAL AVERAGE MEDICARE SPENDING GROWTH FOR VARIOUS PERIODS



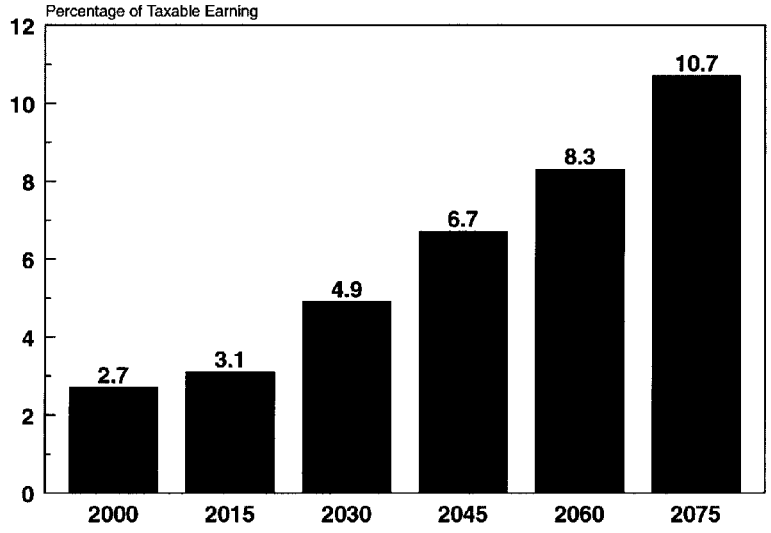
SOURCE: Historical data from the Health Care Financing Administration and Projections by the Congressional Budget Office.

FIGURE 2. PROJECTED MEDICARE OUTLAYS AND DEDICATED REVENUES AS A PERCENTAGE OF GDP, CALENDAR YEARS 2000-2075



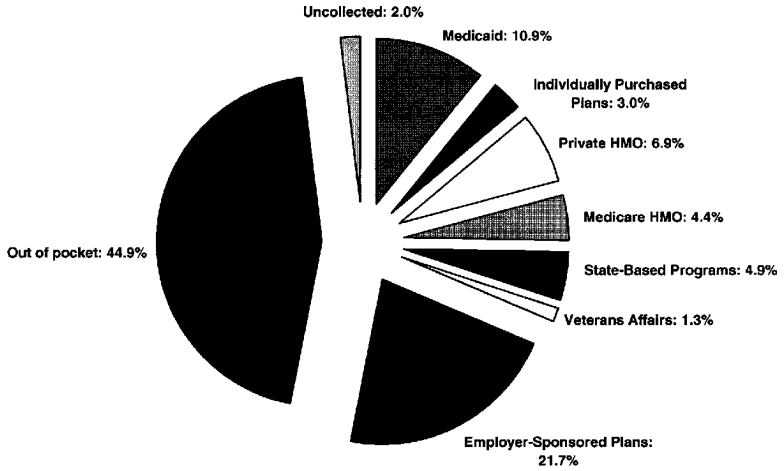
SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund (2001).

FIGURE 3. MEDICARE HI COSTS AS A PERCENTAGE OF TAXABLE EARNINGS, 2000-2075



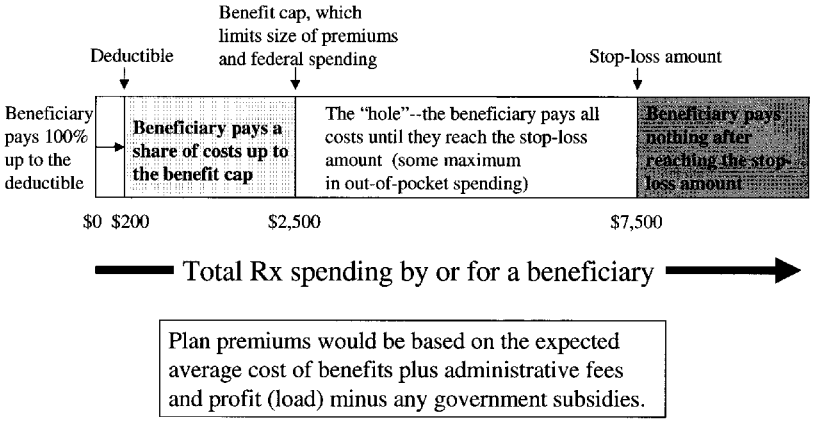
SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund (2001).

FIGURE 4. DISTRIBUTION OF DRUG SPENDING FOR MEDICARE ENROLLEES, BY PAYER, 1997



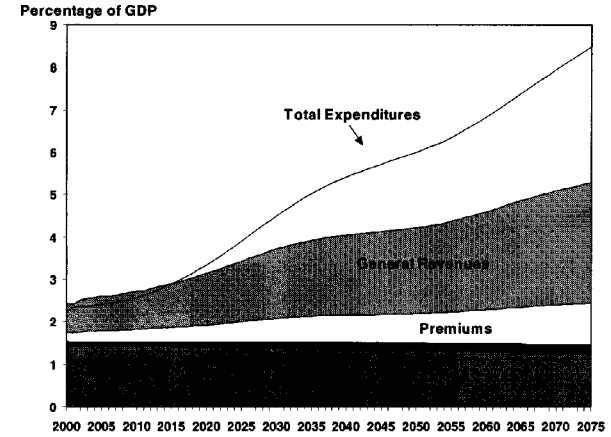
SOURCE: Congressional Budget Office tabulations from the 1997 Medicare Current Beneficiary Survey. Drugs currently covered by Medicare are not included here.

FIGURE 5. POSSIBLE FEATURES OF A PRESCRIPTION DRUG INSURANCE BENEFIT



SOURCE: Congressional Budget Office.

Medicare Expenditures and Noninterest Income as a Percentage of GDP, Calendar Years 2000-2075



Source: Board of Trustees, Federal Hospital Insurance Trust Fund (2001).

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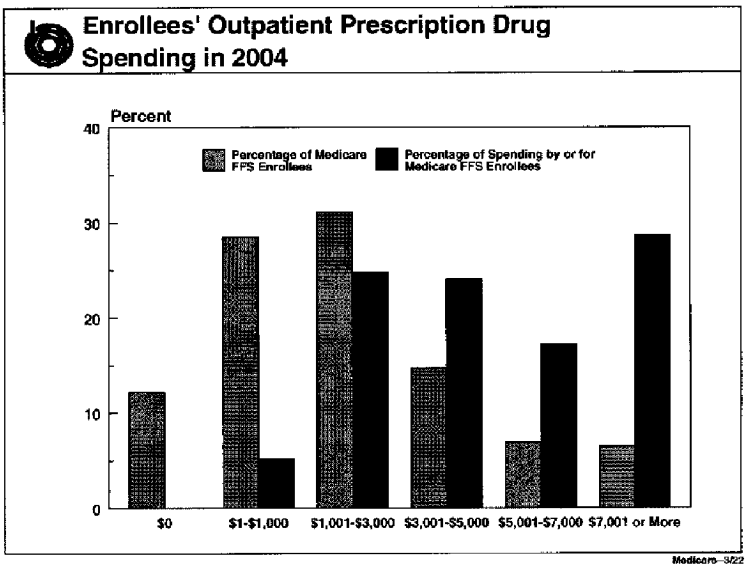
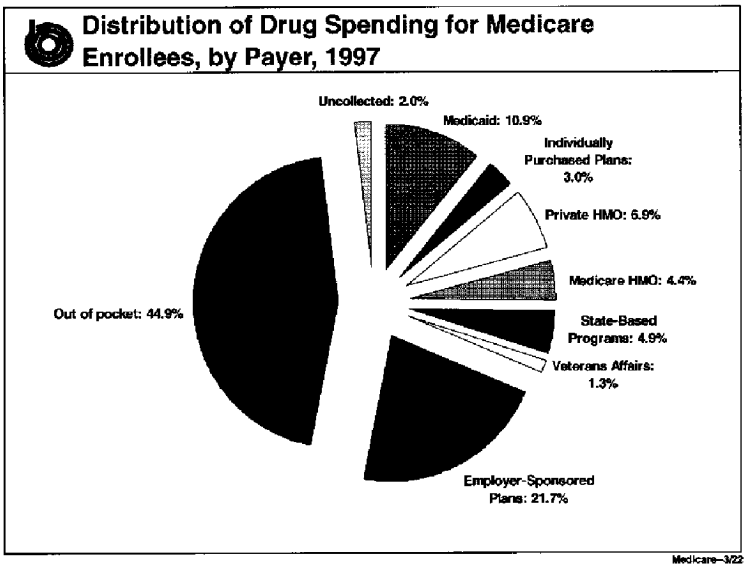
CBO's Baseline Projections of Drug Spending and Medicare Benefits per Enrollee

	Spending per Enrollee (Dollars)		Average Annual Percentage Change, 2002-2011
	2002	2011	
Drug Spending	1,989	4,818	10.3
Medicare Spending	6,512	10,538	5.5

Medicare–3/22





RESPONSES TO QUESTIONS FROM SENATOR ROCKEFELLER

Question: According to new HCFA estimates, reported in the March/April 2001 edition of *Health Affairs* last week, for the general population, prescription drug expenses—which accounted for 9.4 percent of all personal health spending in 1999—will continue to rise at a faster rate than any other category of health care services,

reaching 16 percent of personal health spending in 2010. HCFA predicts that drug costs will grow at an average rate of 12.6 percent a year through 2010. That is roughly the same as CBO's projections of the annual rate of increase in prescription drug spending by seniors.

HCFA attributes this rise in drug costs partially to rising prices for existing drugs. It's amazing to me that despite the fact that almost one-third of Medicare beneficiaries do not have insurance for drug costs, and therefore are paying for these drugs out of their own pockets, drug manufacturers continue to increase prices for existing drugs. We understand that CBO will increase their cost estimates of prescription drug proposals by 33 percent or more due to revised assumptions about drug spending. Can you tell us what amount of this increase is due to increased drug use and what amount is a result of the inflated prices charged by drug manufacturers for their product?

Answer: The Congressional Budget Office's (CBO's) baseline estimate of prescription drug costs for Medicare enrollees is up significantly over last year's. CBO's estimate for 2002 through 2011, the current 10-year projection period, is roughly $1.5 trillion, which is about 32 percent higher than last year's projection for 2001 through 2010. The jump results from assuming a higher rate of growth in per capita drug costs and replacing an early low-cost year (2001) with a late high-cost year (2011).

Last year's analysis indicated that spending by or for Medicare enrollees on outpatient drugs not covered by Medicare would total $1.1 trillion over the period 2001 through 2010. This year, our projection for the same period is $1.3 trillion, or about 18 percent higher (see the table below). The replacement of an estimate for 2001 with one for 2011 accounts for the remaining 14 percent.

One should note that CBO's baseline describes total spending on prescription drugs; it includes the combined effects of increases in drug prices and utilization (the number and average size of prescriptions filled and the substitution of newer drugs for older ones). Thus, the 18 percent increase in CBO's baseline is our measure of the effects of both of those factors over the 2001–2010 period.

Those changes to CBO's baseline estimate—as a result of higher per capita drug spending and the inclusion of a new high-cost year in the projection window—imply that proposals for a prescription drug benefit will have higher price tags than they did last year. But for any given proposal, the exact magnitude of the difference between CBO's previous estimate and its estimate for this year will also depend on the bill's specific features.

COMPARING CBO'S JANUARY 2001 AND MARCH 2000 BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING

[By calendar year, in billions of dollars]

Year	January 2001 Estimates	March 2000 Estimates
2001	71	66
2002	81	74
2003	92	82
2004	104	91
2005	117	101
2006	131	112
2007	148	124
2008	165	137
2009	185	152
2010	205	167
2011	228	n.a.
Total:		
2001–2010	1,299	1,105
2002–2011	1,456	n.a.
Memorandum:.		
Percentage increase in total spending, January 2001 estimates over March 2000 estimates, for 10 years ending in 2010		17.6
Percentage increase in total spending, 10 years ending in 2011 (using January 2001 estimates) over 10 years ending in 2010 (using March 2000 estimates)		31.8

SOURCE: Congressional Budget Office.
NOTES: Numbers may not add up to totals because of rounding.
n.a. = not applicable.

For its baseline estimate, CBO used rates of growth in per capita drug spending from recent projections in the national health accounts, which were developed by the Health Care Financing Administration's (HCFA's) Office of the Actuary. According to the article you cite, HCFA attributes a large portion of the growth to increased use of newer brand-name drugs rather than lower-price generics, and to patients using drug therapies for longer periods of time. HCFA assumes that the introduction of new drugs will continue at a fairly rapid pace over the next decade and that some of those drugs may experience patent protection over a longer period of time than drugs did in the past, thereby continuing upward pressure on drug spending. However, HCFA also expects growth in prices to slow during 2004 and 2005 as a large group of brand-name drugs lose their patent protection.

Question: President Bush has proposed to extend prescription drug coverage to those beneficiaries below 175 percent of the federal poverty level at a cost of $2.5 billion in 2001. However, the President's plan allows states to use federal dollars to replace any spending for prescription drugs above Medicaid coverage—which nationwide, was about $1.1 billion in 2000. This leaves only about $1.4 billion for new coverage. If the average cost per beneficiary were $1,000, this would result in only 1.4 million people receiving help—less than 14 percent of the 10 million Medicare beneficiaries who lack prescription drug coverage.

Alternatively, both CBO and OMB estimate that 100 percent of Medicare beneficiaries will have drug coverage under the Democrats' proposal. Do you agree that it is better to provide drug coverage to 100 percent of Medicare beneficiaries than it is to provide coverage to less than 14 percent of Medicare beneficiaries?

Answer: Under the Bush Administration's Immediate Helping Hand proposal, the federal government would give financial support to states that provide prescription drug benefits to Medicare beneficiaries who are not already eligible for Medicaid and who have incomes of up to 175 percent of the poverty level. Beneficiaries with incomes of up to 135 percent of the poverty level could receive state coverage, paying no premium and only nominal cost sharing; beneficiaries with incomes between 135 percent and 175 percent of the poverty level could receive subsidies for at least 50 percent of a state plan's premium. The President's proposal may also include catastrophic coverage for other Medicare beneficiaries.

CBO cannot estimate how many people would benefit under the proposal because few details are currently available. More fundamentally, although CBO can attempt to compare the effects of a given proposal with its objectives and estimate its associated federal costs, it cannot address the question of which approach is "better."

Responses to Questions From Senator Baucus

Question: In response to my question about potential savings from Medicare reform, you stated that the competition provisions in Breaux-Frist I, Breaux-Frist II, and former President Clinton's "Competitive Defined Benefit" proposal had the potential to achieve substantial savings. Such savings would obviously be important, since they could be used to offset the cost of a prescription drug benefit. Please be more specific about the potential for savings from these proposals. In particular, please comment on the magnitude of any potential savings, and please indicate whether the savings would come primarily from increased efficiencies or from increased beneficiary premiums.

Answer: The Congressional Budget Office (CBO) has estimated that the Clinton Administration's proposal for a competitive defined benefit would generate net savings of $13 billion over 10 years. That estimate comprised savings of $85 billion from lower payments to plans, offset by costs of $72 billion from reduced premiums for beneficiaries who enrolled in the competitive sector. The Breaux-Frist 2000 proposal was a variant of that plan, differing mainly in that it set a higher reference price (which is used to calculate how much to give back to beneficiaries through lower premiums); CBO's estimate for that variant was a net cost of $9 billion over 10 years. Both proposals retained the special status of Medicare's fee-for-service sector, meaning that beneficiaries who chose to remain there rather than enrolling in the competitive sector would not be penalized for doing so.

A proposal that was developed but never formally approved by the Medicare commission would have had greater potential savings because it would have eliminated the special status of Medicare's fee-for-service sector. Under the proposal, the fee-for-service plan would have had to compete equally with all other plans, and enrollees who remained in the fee-for-service sector would have had to pay substantially higher premiums if that plan was more expensive than other plans. CBO has not prepared an estimate for that proposal, but the actuaries of the Health Care Financing Administration have done so. They estimated that the version of the premium support model (exclusive of any provision for an income-related premium) would

produce savings of between $75 billion and $102 billion over the 2000–2009 period. A large share of those savings would have been due to higher premiums paid by beneficiaries who remained in the fee-for-service sector.

Question: In your written statement, you contend that "If only costs above $5,000 a year were covered, costs through 2011 would be about $365 billion." Please provide an estimate if only costs above $6,000 a year were covered, holding all other factors constant. Conversely, if the costs through 2011 were $153 billion, what is the corresponding stop-loss amount, again holding other factors constant?

Answer: The table below shows CBO's baseline projections of federal drug costs for the calendar year 2002 through 2011 under different assumptions about the federal government's and enrollee's contributions. Only costs per enrollee above the values shown as deductibles are counted. Thus, federal costs over the 10-year period under Case A—which has no deductible, premiums, or cost sharing—are projected to be $1.5 trillion. If a Medicare benefit covered all drug spending above $5,000 annually, federal costs would total $365 billion. A benefit covering spending above $6,000 per enrollee would cost $286 billion over the 10-year period, while coverage of all spending above $9,000 per enrollee would total roughly $150 billion.

The amounts shown under Case A represent the approximate cost of a Medicare drug benefit if the benefit covered all costs above the specified deductible amount and no premiums were imposed on enrollees. Even under those conditions, a number of adjustments would have to be made to generate an accurate cost estimate, including adjustments for utilization, cost management, administrative expenses, and the conversion from a calendar year to fiscal year basis. As a result, the table below and the numbers described here are not official cost estimates.

If, for example, half the costs of the benefit were financed by enrollees' premiums (Case B), then the approximate net federal cost of covering all drug costs above $6,000 per enrollee over the 10-year period would be $143 billion. Alternatively, if the benefit imposed a 50 percent coinsurance requirement above the deductible amount and 50 percent of benefit costs were financed by enrollees' premiums (Case C), then the deductible amount could be reduced to $3,000 and net federal costs would be about $154 billion. Those estimates assume that all Medicare enrollees participate in the benefit; in addition, they do not include any costs for subsidies targeted toward low-income beneficiaries.

APPROXIMATE FEDERAL COSTS FOR A MEDICARE PRESCRIPTION DRUG BENEFIT UNDER ALTERNATIVE ASSUMPTIONS, CALENDAR YEARS 2002–2011

[In billions of dollars]

Deductible (Dollars)	Case A[a]	Case B[b]	Case C[c]
0	1,456	728	364
500	1,254	627	313
1,000	1,084	542	271
2,000	814	407	203
3,000	616	308	154
4,000	472	236	118
5,000	365	183	91
6,000	286	143	71
7,000	226	113	57
8,000	181	90	45
9,000	146	73	36
10,000	119	59	30

SOURCE: Congressional Budget Office.

[a] Medicare pays all costs above the deductible; enrollees pay no cost sharing or premiums.
[b] Medicare pays all costs above the deductible; enrollees pay 50 percent of benefit costs through premiums.
[c] Medicare pays 50 percent of costs above the deductible; enrollees pay 50 percent of benefit costs through premiums.

Question: In questioning, Senator Bob Graham described a proposal that would give beneficiaries a choice between a catastrophic-only policy or a full benefit package, with an equivalent government premium contribution toward each option. The rationale for providing two choices would be to allow beneficiaries with existing coverage to select the catastrophic-only policy, while those currently uninsured could select the full package. The assumption is that this approach would do a better job of keeping private dollars in the system. Please comment on the validity of this assumption. Would employers be more likely to continue providing retiree coverage if their retired workers could wrap around their coverage with a catastrophic policy? Are there other policies or provisions aimed at preserving employer-sponsored re-

tiree coverage that you have scored? Please comment on the effectiveness or impact of these policies.

Answer: Employer-sponsored coverage for prescription drugs through retiree health plans has been declining in recent years in two main ways. Some employers have eliminated their coverage for retirees; most have just reduced the share of the premium that they pay. A new drug benefit under Medicare would probably increase the willingness of employers to retain their existing retiree health plans, at least in the near term, regardless of the form of that new benefit, because it would reduce their costs for those plans.

CBO assumes that existing retiree health plans would coordinate their coverage with a new Medicare drug benefit in the same way that they typically coordinate their benefits with Medicare's hospital and physician benefits, using the so-called carve-out method. Under the carve-out coordination method, retiree health plans calculate the benefit they would pay under their benefit structure, subtract the benefit paid by Medicare, and pay the remainder to providers or beneficiaries.

Hence, a new Medicare drug benefit of any form would reduce employers' costs for retiree health plans, assuming that employers did not pay the Medicare premium for retirees. And even employers who did pay their retirees' Medicare premiums would see their costs fall if the Medicare premium was partially subsidized by the federal government.

It also seems likely that employers would effectively require retirees to enroll in the more comprehensive Medicare benefit, because that would reduce their costs by more than would the catastrophic plan. (Employers could effectively require enrollment in the Medicare drug benefit, just as they do now for Part B, by calculating the retiree plan benefit as though Medicare's benefit payment had been made, whether or not the retiree chose to enroll in Medicare.)

The Medicare prescription drug proposal developed by the Clinton Administration provided a subsidy to employers who chose to retain their retiree health plan coverage as their retirees' primary payer. For its cost estimate of that proposal, CBO assumed that 25 percent of people with drug coverage through a retiree health plan would keep that coverage as primary because of the subsidy. That assumption was based on responses given by employers to a survey asking them how they would respond if the Clinton plan was enacted.

PREPARED STATEMENT OF STEPHEN CRYSTAL

Chairman Grassley, Senator Baucus, and Members of the Committee: Thank you for the opportunity to testify today on Medicare reform issues. I want to thank as well my colleagues at the Rutgers Center for State Health Policy on our study currently in progress for the Commonwealth Fund on state pharmacy assistance programs—Kim Fox, Tom Trail, Mina Silberberg, Susan Reinhard, and Joel Cantor. Our work is at a preliminary stage since we are currently in the early stages of state case studies for the project. During the coming months we will have much more information on the questions I was asked to address. However, we do have some basic data reported to us by states with direct benefit pharmacy assistance programs in a mail survey that we conducted between September 2000 and January 2001, and partial information from case studies in progress of several of these states that may be useful to you at this stage. We have included tables that reflect the information reported to us by the states; they are preliminary data since we are still in the process of double-checking with the states the information that they returned to us on the surveys, but they provide a good overall picture of the current landscape of state pharmacy assistance programs.

Based on the mail survey, we estimate that total enrollment in state direct benefit pharmacy assistance programs operating throughout 2000 was approximately 860,000. Although enrollment may have increased slightly in 2001 due to program startups and expansions, we estimate that fewer than 3% of Medicare beneficiaries are enrolled in state direct benefit programs. These programs are typically targeted to individuals whose incomes are low but above Medicaid eligibility levels. They are of great importance to participants, since out-of-pocket health care costs and particularly prescription drug costs represent a significant burden to individuals in these income ranges. For example, in a recent study in the Journal of Gerontology using data from the Medicare Current Beneficiary Survey, we estimated that health care expenditures accounted for 32% of income for older persons in the lowest fifth of the income distribution and 24% for those in the second lowest fifth. In both quintiles, prescription drug costs accounted for 40% of out-of-pocket payments for health care goods and services, a higher proportion than for higher-income people.

However, these programs are far from constituting a national drug safety net. They constitute a spotty and uneven system in which protection for older Americans depends on where they live. While 14 states operated direct benefit programs throughout the year 2000, 49% of the enrollment was in just two states, Pennsylvania and New Jersey, and 72% was in these two states plus New York and Massachusetts. In six states—Maine, Vermont, Rhode Island and Delaware, plus Pennsylvania and New Jersey—enrollments exceeded 10% of Medicare enrollment in the state. Many of the programs are more limited, however; for example, some cover only certain types of drugs or persons with certain conditions. From a national perspective, the proportion of Medicare beneficiaries enrolled in state direct benefit programs is relatively small. It probably represents a somewhat higher proportion of Medicare beneficiaries' prescription drug spending, however, since those with high drug spending are likely to enroll disproportionately in the plans. The programs are highly popular and state legislators hear frequently from their constituents about the need to create or expand them. However, despite the fact that several states are launching new programs and several existing programs are expanding eligibility, existing programs report that they are under considerable financial pressure in the face of steadily rising pharmaceutical costs.

Eligibility, cost-sharing, and other program characteristics vary widely across states. In addition to income-eligible persons aged 65 and over, seven of the programs also cover disabled residents, and two programs, Maryland and Wyoming, cover all residents who meet the income requirements regardless of age or disability. States that cover disabled residents generally find that these enrollees use more prescription drugs and cost more per person to cover than do elderly enrollees. All the programs except Nevada's are operated directly by the states, with assistance of contracted pharmacy benefit managers in a few cases. Nevada, after considerable initial difficulty in securing an interested vendor, has recently implemented a program under which state funds are used to subsidize private pharmacy insurance policies. As this program evolves, Nevada's experience will be of interest in connection with legislative options that would create stand-alone pharmacy insurance policies.

People we've interviewed in the states have been concerned about consumers whose incomes put them just over income limits, but who have great need for prescription drug coverage. A few states have dealt with this issue by allowing individuals with incomes over the limits to qualify for the program if they spend a certain percentage of their income on prescription drugs (40% in Delaware and Maine, 10% in Massachusetts, 3% in Rhode Island). In addition, states report constant pressure from consumer groups to increase eligibility limits above the current levels.

Income eligibility ceilings range widely. Four states have eligibility limits at or below 135% of the federal poverty line, while three make some benefits available to persons at more than 400% of poverty. The majority, however, have ceilings in the range from 150% to 260% of poverty. New Jersey, for example, provides a comprehensive benefit to persons up to about 230% of the poverty line and is considering legislation to provide another tier of benefits, at a higher copayment, to those with higher incomes. Only two states impose asset limits for eligibility, and one of those two, Minnesota, recently substantially raised its asset limit.

The more generous programs, such as those in New Jersey, Pennsylvania, and Vermont, operate on a drug benefit model similar to that of Medicaid: almost all drugs are covered for a nominal ($6 or less) co-pay with no fees, no deductible, and no maximum benefit. Other programs have slightly less generous benefits, but still cover most prescription drugs available under Medicaid.

These programs use various combinations of deductibles, coinsurance, fees, and/or benefit maximums, although the experience with programs with high up-front fees has been that this strategy substantially depresses enrollment. Generally, programs report that initially, considerable outreach and consumer education is necessary for consumers to understand the plans and to encourage those eligible to apply.

Several programs have substantial deductibles, particularly for those above the lowest eligible income tier. South Carolina and Pennsylvania's PACENET program have a $500 annual deductible, and Minnesota has a $35 monthly deductible. Both Massachusetts and New York offer coverage with sliding scale fees and/or deductibles based on income. In New York, enrollees either pay an annual fee ranging from $8 to $230 (singles) if they are in a lower income bracket or an annual deductible ranging from $530 to $1,230 (singles) if they are in a higher income bracket. Massachusetts enrollees pay both a monthly fee ranging up to $82 and an annual deductible ranging up to $500. Both of these programs also have tiered copays based on the cost or type of drug, and both have annual out of pocket maximums—$2,000 or 10% of annual income in Massachusetts and 6% of annual income

(singles) in New York (8% for couples). A few active programs have annual caps on benefits: Delaware has a $2,500 annual cap, Indiana has a $500 to $1,000 tiered benefit cap, Florida has an $80 monthly benefit cap, and Michigan has had a limit of three months worth of prescriptions up to three times a year, which we understand is being modified. Nevada's new program has monthly premiums and a $5,000 annual benefit cap.

In thinking about the challenges faced by these programs and their implications for a Medicare benefit, perhaps the most recurrent challenge cited by state officials we interviewed is the tension between ever-increasing pharmacy costs and pressures to maintain and expand program coverage driven by the high level of need. The trend in per-participant annual program costs has been sharply upwards. Programs that have made dedicated funds available to pharmacy programs and other health programs, such as lottery revenues in Pennsylvania and casino revenues in New Jersey, have seen the pharmacy programs outstripping the revenue sources and crowding out other programs or spilling over into general revenues. The stability of funding for the programs in the future is uncertain, particularly if very recent trends suggesting a deterioration of state budgetary outlooks continue. Cost containment is a constant struggle for the programs, who have pursued a variety of avenues, often in the face of opposition either from manufacturers, pharmacist organizations or consumer advocates, depending on who is impacted by a particular strategy. At the same time, there are chronic pressures to expand coverage to the groups just above the eligibility limit, wherever it is set. Although they hear loud and clear from their constituents about the magnitude of the need, states are therefore also concerned about the financial implications for state budgets of maintaining or expanding their role in pharmacy assistance.

I was asked to think about how states might respond if a universal voluntary benefit were created. This would certainly vary from state to state and would depend a lot on the type of benefit that was created and on the budget situation facing a state in a given year. If a federal benefit were less generous than the benefits in place in a state, that state would be under constituent pressure to wrap around the federal benefits so as to make up the difference. Some would like to use funds freed up from pharmacy benefits to cover additional individuals beyond their present eligibility levels. However, pharmacy assistance would be competing with many other budgetary demands for these funds. States have, as you know, opposed any maintenance-of-effort requirement, arguing that this would constitute penalizing states that have taken the initiative.

If a federal benefit is less generous than some of the state programs, it would be desirable to make it as straightforward as possible for states to supplement or "wrap around" the federal benefit. State program administrators are concerned that unless provisions for this are designed into the system, coordination of benefits problems could be very difficult and could possibly become a disincentive for states to maintain their efforts. Coordination of benefits in the current system—for example, with the existing limited outpatient pharmacy coverage in fee-for-service Medicare or with Medicare+Choice and employer-based plans—is already a difficult problem for state pharmacy programs. While they are typically mandated to be the payer of last resort, they often are unable to recover from other payers due to lack of accurate information and the technical difficulties of coordinating benefits. There are a variety of ways in which states could be encouraged to maintain their efforts if a federal benefit is created. They could, for example, be given the option of administering a federally-funded benefit in their state, in which case supplementing the basic benefit with state funds would be straightforward. If private pharmacy-only insurance products are subsidized, these programs could be required to make enrollment and benefits information available to states operating pharmacy assistance programs. Alternatively, states could drop their existing programs and shift to a supplemental premium support role, but how this would work is uncertain and it could also involve considerable challenges of coordination.

The state pharmacy programs might also play a useful role in eligibility determination for means-tested federal prescription drug subsidies. It has been suggested, I believe in one version of the Breaux-Frist proposals, that this responsibility be assigned to state Medicaid agencies. People we interviewed from the state pharmacy assistance programs were concerned that this could be a significant barrier to participation because of the perceptions of welfare stigma that Medicaid and the Medicaid agencies carry for many older people. They were also concerned about the possibility of eligibility being restricted to individuals who meet the asset limitations of the QMB program, which are perceived as extremely restrictive and as barring many low-income individuals who are severely burdened by pharmacy costs. Such an asset test might be strongly unpopular with beneficiaries and limit enrollment in new programs.

A final area of concern has to do with the issue of consumer confusion over complex plan requirements. Beneficiaries are often confused about even basic concepts in the state programs such as the difference between a deductible and a premium. States are concerned that beneficiaries, already challenged by the complexity of Medicare, Medicare+Choice plans and supplementary insurance, will find it very difficult to effectively evaluate, in addition, a variety of choices for pharmacy coverage. They anticipate that this would engender considerable additional burden on already-overburdened health insurance counseling services such as those offered through area agencies on aging.

Clearly, your Committee is struggling with a most challenging and complex policy problem, in a system with many moving parts. The absence of outpatient prescription drug coverage in the traditional Medicare program is by now widely seen as a serious problem for many beneficiaries. The traditional program is still where most beneficiaries are, either by their own choice or because Medicare+Choice plans are not available in their areas. Many states have struggled, each in their own way, with the attempt to fill this gap, but have felt under considerable financial pressure in attempting to address this very expensive problem at the state level. Many of the states have, however, acquired a great deal of valuable experience which should be built on as the provision of pharmacy coverage evolves. For example, the prospective drug utilization review systems developed by Pennsylvania serve not only as a means of cost containment but also as a vehicle for important health care quality and medical error reduction purposes.

The effort to provide both a universal voluntary benefit with some subsidy, and more significant financial protection to lower-income individuals, within limited funds is indeed a great challenge. In thinking about how to address this problem, a broad concern that grows out of our interviews with state stakeholders is the impact of existing complexity and fragmentation in the financing of health care for Medicare beneficiaries, and the desirability of attempting to minimize rather than increase it. As people in state agencies, who interact with elderly and disabled consumers on an ongoing basis, are only too well aware, many consumers find it difficult to understand the coverage choices and multiple payers involved in the existing system. In concept, policy options which would aim at creating a market for competing, subsidized private pharmacy-only policies with differing benefit structures could add to consumer choice. However, the tradeoffs might include building in increased administrative complexity and costs into the system, increased beneficiary confusion, and making it administratively more difficult for states to supplement federally supported benefits. Several of our respondents were concerned about how effectively their beneficiaries would be able to assimilate and evaluate information on new, complex choices on pharmacy coverage, and spoke to the value of considering the benefits of simplicity and comprehensibility along with those of choice in building pharmacy benefits into the system.

As we move forward with our study in the coming months, complete additional state case studies, and prepare analyses on the process of program implementation and the impact of alternative benefit designs for state pharmacy assistance programs, variation in benefit takeup, and program management strategies including drug utilization review, we will be happy to be of any further service we can be to the Committee. In conclusion, I would like to thank the Committee again for the opportunity to testify, and will be happy to address any questions.

Table 1. State Programs by Type of Program and Date of Implementation

States with Direct Benefit Programs Only (16 States)

State	Program Name	Program Type	Implemented
Connecticut	Connecticut Pharmaceutical Contract to the Elderly and Disabled (ConnPACE)	Direct benefit with $12 co-pay and $25 annual fee	April 1985
Delaware	Nemours Health Clinic Pharmacy Assistance Program (private initiative)	Direct benefit with $5 co-pay, 20% coinsurance, and $2,000 annual benefit cap	September 1981
	Delaware Prescription Drug Assistance Program (DPAP)	Direct benefit with $5/25% co-pay/coinsurance and $2,500 annual benefit cap	January 2000
Illinois	Pharmaceutical Assistance Program (PAP)	Direct benefit with $0/$5 co-pay and $5/$25 annual fee	July 1985
Indiana	Indiana Prescription Drug Fund: "HoosierRx"	50% coinsurance with $500 to $1,000 tiered annual benefit cap	September 2000
Kansas	Senior Pharmacy Assistance Program	Direct benefit with 30% coinsurance and $1,200 annual benefit cap	Expected July 2001
Maryland	Maryland Pharmacy Assistance Program	Direct benefit with $5 co-pay	January 1979
Massachusetts	The Pharmacy Program	Direct benefit with $15 annual fee, $3/$10 co-pay, and $1,250 annual benefit cap	July 1997
	The Pharmacy Program Plus	Direct benefit with $3/$10 co-pay	January 2000
	Prescription Advantage Program	Direct benefit with $0/$82 sliding scale monthly premium, $0/$500 sliding scale annual deductible and $5/$12/50% tiered co-pay	April 2001
Minnesota	Prescription Drug Program (PDP)	Direct benefit with $35 monthly deductible	January 1999
Nevada	SenioRx Insurance	Insurance subsidy with $75/$98 monthly subsidized premiums, $100 annual deductible, $10/$40 tiered co-pay, and $5,000 annual benefit maximum	January 2001
New Jersey	Pharmaceutical Assistance for the Aged and Disabled (PAAD)	Direct benefit with $5 co-pay	March 1976

States with Direct Benefit Programs Only (16 States) continued.

State	Program Name	Program Type	Implemented
New York	Elderly Pharmaceutical Insurance Coverage (EPIC)	Direct benefit with $3/$20 tiered co-pay and either $8/$230 sliding scale annual fee or $530/$1,230 annual deductible	October 1987
North Carolina	Prescription Drug Assistance Program	Direct benefit with $6 co-pay	July 2000
Pennsylvania	Pharmaceutical Assistance Contract for the Elderly (PACE)	Direct benefit with $6 co-pay	July 1984
	Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier (PACENET)	Direct benefit with $8/$15 co-pay and $500 annual deductible	November 1996
Rhode Island	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)	Direct benefit with tiered 40%/85% coinsurance	October 1985
South Carolina	Seniors' Prescription Drug Program	Direct benefit with $10/$21 co-pay and $500 annual deductible	January 2001
Wyoming	Minimum Medical Program (MMP)	Direct benefit with $25 co-pay	1988

States with Discount or Tax Credit Programs Only (6 States)

State	Program Name	Program Type	Implemented
California	Drug Discount Program for Medicare Beneficiaries	Medi-Cal reimbursement rate discount	February 2000
Iowa	State prescription drug purchasing co-operative	Discount drug purchasing co-op	Expected July 2001
Missouri	Pharmaceutical Tax Credit	$200 tax credit	1999 tax year
New Hampshire	Senior Prescription Drug Discount Pilot Program	Pharmacy Benefit Manager discount program	January 2000
Washington	A Washington State Alliance to Reduce Prescription Drug Spending (AWARDS)	Pharmacy Benefit Manager discount program	January 2001
West Virginia	Senior Prescription Assistance Network II (SPAN II)	Public Employee Insurance Agency discount	December 2000

States with Direct Benefit Programs and Other Programs (4 States)

State	Program Name	Program Type	Implemented
Florida	Pharmaceutical Expense Assistance Program	Direct benefit with 10% coinsurance and $80 monthly benefit cap	January 2001
	Medicare Prescription Discount Program	State-mandated discount	July 2000
Maine	Low Cost Drugs for the Elderly or Disabled	Direct benefit with $2/20% co-pay/ coinsurance	1975
	Maine Rx	State negotiated discount	Expected April 2001
	Healthy Maine Prescription Program	HCFA waiver for discount at Medicaid reimbursement rate minus average rebate	Expected 2001
Michigan	Michigan Emergency Pharmaceutical Program for Seniors (MEPPS)	Direct benefit with 25¢ co-pay and 3 month prescription limits	1988
	Prescription Drug Credit program	$600 tax credit	1988
	Elder Prescription Insurance Coverage (EPIC)	Direct benefit — details to be determined	Expected 2001
Vermont	Vermont Health Access Program (VHAP)	Direct benefit with $1/$2 co-pay	January 1996
	VScript	Direct benefit with $1/$2 co-pay	1989
	VScript expanded	Direct benefit with 50% coinsurance	January 2000
	Pharmacy Discount Program (PDP)	HCFA waiver for discount at Medicaid reimbursement rate minus average rebate	January 2001

* Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; the Health Insurance Association of America's September 2000 report on state pharmaceutical assistance programs *State Pharmaceutical Assistance Programs Continue to Grow*. Washington, DC; and the National Conference of State Legislatures' web site: *State Senior Pharmaceutical Assistance Programs*, http://www.ncsl.org/programs/health/drugaid.htm.

Table 2: States with direct benefit programs, year implemented and eligibility requirements.

State	Year 2000 Income Requirements (%FPL)	Year 2001Income Requirements (% FPL)	Elderly	Disabled
Connecticut	178%	180%	65	18
Delaware				
Nemours	152%	150%	65	—
DPAP	200%	200%[a]	65	19
Florida	—	120%	65	—
Illinois	194%	254%	65	16
Indiana	135%	135%	65	—
Kansas	—	150%	67	—
Maine	185%	185%[b]	62	19
Maryland	117%	116%	No age restrictions	
Massachusetts				
Pharmacy Program	191%	—	65	No minimum
Pharmacy Program +	500%	—	65	No minimum
Prescription Advantage	—	500%[c]	65	No minimum
Michigan	150%	150%	65	—
Minnesota	120%	120%	65	—
Nevada	—	257%	62	—
New Jersey	226%	230%	65	18
New York	225%	419%	65	—
North Carolina	150%	150%	65	—
Pennsylvania				
PACE	170%	168%	65	—
PACENET	194%	192%	65	—
Rhode Island	189%	419%[d]	65	—
South Carolina	—	175%	65	—
Vermont				
VHAP	150%	150%	65	No minimum
VScript	175%	175%	65	No minimum
VScript Expanded	225%	225%	65	No minimum
Wyoming	100%	100%	No age restrictions	

Notes: The FPL for year 2000 income was $8,350 for single individuals. In some states, eligibility requirements are set as a percentage of poverty line; in others, we have calculated percentage of poverty line based on eligibility levels set in dollar terms.

[a] Applicants in Delaware who have prescription drug expenses in excess of 40% of their income are eligible for the program regardless of their income.

[b] In Maine, if an applicant spends 40% or more of his/her income on prescription drugs, the income limits are 25% higher.

[c] Massachusetts' new program in effect April 2001 has no upper income limit. Premiums and deductibles are subsidized on a sliding scale for enrollees with incomes below 500% of FPL. Enrollees with incomes below 188% of FPL pay no premiums or deductibles. This program replaces the Pharmacy and Pharmacy Plus Programs.

[d] When calculating income eligibility, Rhode Island's program excludes medical and pharmaceutical expenses exceeding 3% of an applicant's annual income.

* Source: Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; and the National Conference of State Legislatures' web site: *State Senior Pharmaceutical Assistance Programs*, http://www.ncsl.org/programs/health/drugaid.htm.

Table 3: Enrollment as a Percentage of Medicare Enrollment in State Direct Benefit Programs Operating Throughout 2000

State	Year 2000 Enrollment	Percentage of Medicare Enrollees in State
Connecticut	30,546	6.0%
Delaware (all programs)	12,630	11.5%
Illinois	51,823	3.2%
Maine	40,277	18.6%
Maryland	41,261	6.5%
Massachusetts (all programs)	69,770	7.3%
Michigan	12,591	1.1%
Minnesota	4,833	0.8%
New Jersey	187,358	15.7%
New York	126,302	5.4%
Pennsylvania (all programs)	237,190	12.7%
Rhode Island	33,000	22.4%
Vermont (all programs)	11,175	12.9%
Wyoming	550	0.9%
Total	**859,306**	**7.5%****

Source: Enrollment numbers come from the Rutgers Center for State Health Policy Survey of State Pharmaceutical Assistance Programs, December 2000; and the National Conference of State Legislatures' web site: *State Senior Pharmaceutical Assistance Programs*, http://www.ncsl.org/programs/health/drugaid.htm. State Medicare enrollment data are from the HCFA web site, *Medicare County Enrollment as of July 1, 1999: Aged and Disabled 3/2000 update*. http://www.hcfa.gov/stats/. Medicare enrollment figures used as denominators do not include disabled enrollees for states where disabled persons are not eligible for the pharmacy assistance program.

**Ratio of enrollment in states with programs to Medicare enrollment in those states.

PREPARED STATEMENT OF RICHARD S. FOSTER, F.S.A.

Chairman Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medicare program as shown in the recently released 2001 annual reports of the Medicare Board of Trustees. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program-one that is a critical factor in the income security of the our aged and disabled populations.

The financial outlook for the Medicare program presents a mixed picture. Over the next 10 years, the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are adequately financed and meet the Trustees' formal tests for short-range financial adequacy. The depletion of the HI trust fund, which had been projected for 2025 in last year's Trustees Report, has been postponed to 2029 in the new estimates.

Over the long range, in contrast, HI and SMI expenditures are projected to grow more rapidly than in previous reports as a result of revised long-range Medicare cost growth assumptions. The assumption change was recommended by the 2000 Medicare Technical Review Panel, an independent, expert group of actuaries and economists convened by the Board of Trustees to review the Medicare financial projections. HI tax revenues are projected after 2015 to fall increasingly short of program expenditures, eventually covering only one-third of estimated costs by the end of the Trustees' 75-year projection period. For SMI, continuing rapid expenditure growth would place growing financial burdens both on beneficiaries and on the Federal budget. The SMI trust fund would remain in financial balance indefinitely, however, due to the annual redetermination of program financing.

BACKGROUND

Roughly 39 million people were eligible for Medicare benefits in 2000. HI, or "Part A" of Medicare, provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth.

Only about 22 percent of HI enrollees received some reimbursable covered services during 2000, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incur reimbursable SMI costs because the covered services are more routine and the annual deductible for SMI is only $100.

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

SMI enrollees pay monthly premiums ($50.00 in 2001) that cover about 25 percent of program costs. The balance is paid by general revenue of the Federal government and a small amount of interest income.

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

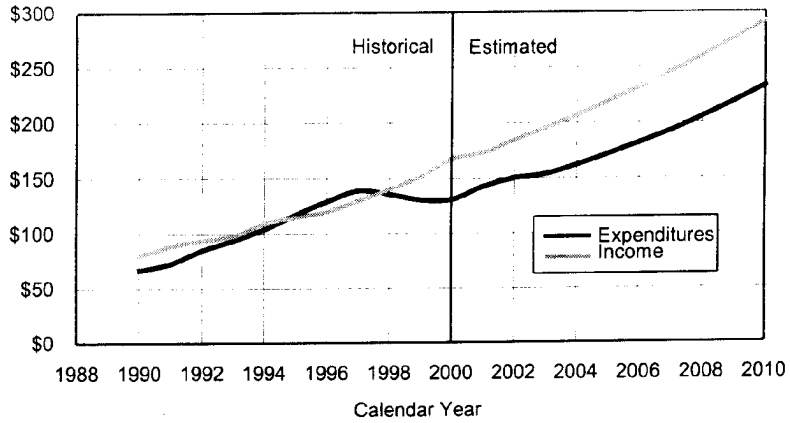
Each part of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 2001 reports to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10 years) and a "long range" (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

SHORT-RANGE FINANCIAL OUTLOOK FOR HOSPITAL INSURANCE

Chart 1 shows HI expenditures versus income over the last 10 years and projections through 2010. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year are intended to be roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities.

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

Chart 1—HI expenditures and income
(In billions)



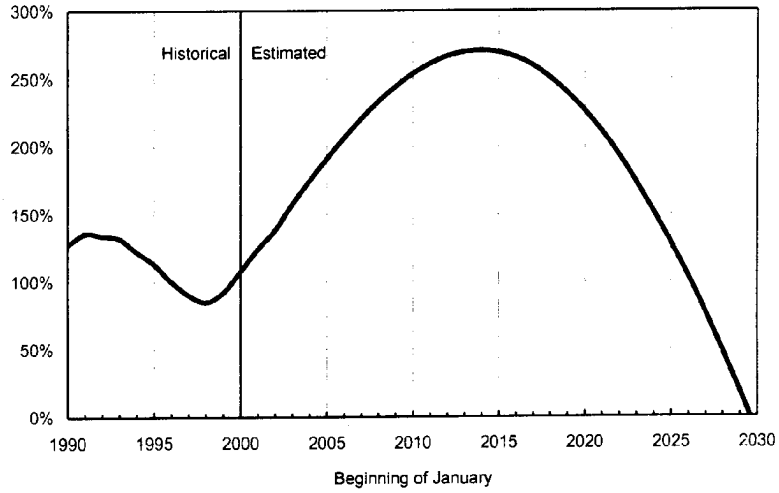
During 1990–97, HI costs increased at a faster rate than HI income. Expenditures exceeded income by a total of $17.2 billion in 1995–97. Prior to the Balanced Budget Act of 1997, this trend was expected to continue, with costs growing at about 8 percent annually, against revenue growth of only 5 to 6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

The Board of Trustees has recommended maintaining HI assets equal to at least one year's expenditures as a contingency reserve. As indicated in chart 2, HI assets at the beginning of 2001 represented about 125 percent of estimated expenditures for the year. The HI trust fund is estimated to continue to experience significant surpluses for about the next 15 years. After 2020, however, expenditures are projected to again exceed income. As shown in chart 2, assets would initially accumulate rapidly but then be drawn down to cover the resulting shortfalls. The trust fund would be exhausted in 2029 under the Trustees' intermediate assumptions.

The depletion date estimated in the 2001 Trustees Report represents a significant improvement compared to the estimate in last year's report (2025). The improvement arises from higher payroll tax revenues and income taxes on Social Security benefits in 2000 than had been estimated, together with assumed faster economic growth over the next 10 years. In addition, benefit expenditures in 2000 were lower than estimated, and adjustments have been made to projected expenditure growth for the future based on this experience. The higher payroll taxes in 2000 resulted from robust economic growth, particularly the rapid growth in productivity and wages. Lower-than-expected HI expenditures reflected a reduction in the utilization of skilled nursing facility services, low increases in health care costs generally, and continuing efforts to combat fraud and abuse in the Medicare program.

Chart 2—HI trust fund assets

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



2000 MEDICARE TECHNICAL REVIEW PANEL

The projections in the new Trustees Reports also reflect a number of recommendations made by the 2000 Medicare Technical Review Panel. The impact of these recommendations on the HI projections for the first 25 years were largely offsetting and had a minimal impact on the estimated year of asset depletion.

The Technical Panel was convened by the Board of Trustees in 2000 to review the financial projections in the Medicare Trustees Reports. It was made up of seven independent health actuaries and health economists, who were nominated by the prior public members of the Board of Trustees. The panel met from June through November 2000 and issued its final recommendations in December 2000.

The panel unanimously found that the projection work of the Office of the Actuary at the Health Care Financing Administration was of excellent quality and was performed in a highly competent and completely professional manner. Overall, the members concluded that the methods and assumptions used to project the status of the Medicare program were reasonable, with the exception of the long-range expenditure growth assumption, which they believed to be too low. In addition to their recommendation to increase this growth rate assumption, the panel issued 37 other findings and recommendations.

For the 2001 Trustees Reports, the Medicare Board of Trustees adopted all of the panel's recommendations that could realistically be incorporated within the short time available following the panel's report. These included the recommended long-range growth assumptions, corresponding adjustments to short-range "case-mix" growth assumptions, an improvement in certain assumptions relating to the costs for beneficiaries who switch from fee-for-service coverage to Medicare+Choice plans, and several recommendations regarding the content of the Trustees Reports. The Board will consider the panel's remaining recommendations for possible inclusion in future reports, as time and available health research knowledge permit.

In past Trustees Reports, increases in the average HI cost per unit of service were assumed to gradually decline after the first 15 years and to equal growth in average hourly earnings during the final 50 years of the projection. The last expert review panel, in 1991, concluded that the assumption was "not unreasonable" but recommended that it be monitored carefully in subsequent years. The 2000 Technical Panel recommended that average HI and SMI expenditures per beneficiary be assumed to increase at the rate of per capita GDP plus one percentage point. They based this recommendation primarily on the historical impact of advances in medical technology on health care cost increases, which they expected to continue indefinitely. They also considered other factors contributing to health care cost growth, the assumptions of other forecasters, and the "sustainability" of such cost increases

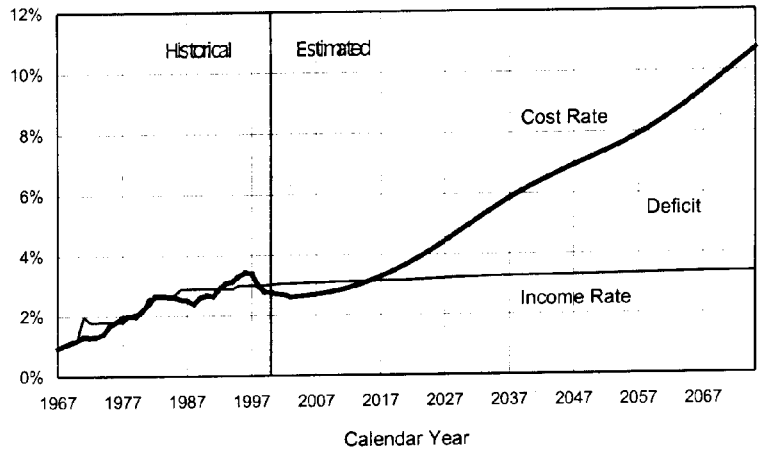
in the very long range. Although they acknowledged the remaining (and considerable) uncertainty regarding health expenditure growth rates over very extended periods, the panel concluded that there is substantially greater evidence in favor of the faster growth assumption than there is in support of the prior HI and SMI Trustees Report assumptions. I concur with their conclusion, as does the Board of Trustees.

LONG-RANGE FINANCIAL OUTLOOK FOR HOSPITAL INSURANCE

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

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

Chart 3—Long-range HI income and costs under intermediate assumptions
(as a percentage of taxable payroll)



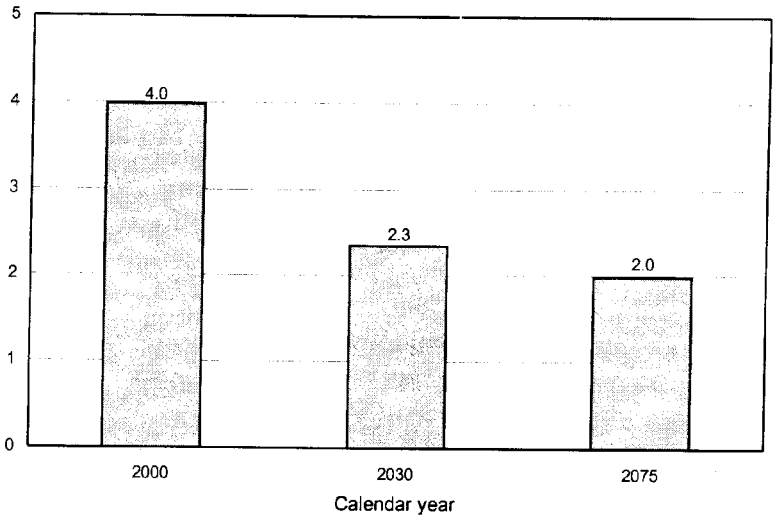
Past HI cost rates have generally increased over time but have periodically declined abruptly as the result of legislation to expand HI coverage to additional categories of workers, raise (or eliminate) the maximum taxable wage base, introduce new payment systems such as the inpatient prospective payment system, etc. Cost rates decreased significantly in 1998–2000 as a result of the Balanced Budget Act provisions together with strong economic growth. After 2002, however, cost rates are projected to increase steadily and accelerate significantly with the retirement of the baby boom, beginning in about 2010. As a result of the revised long-range expenditure growth assumption, projected cost rates after 2030 are substantially greater than the corresponding estimates in last year's Trustees Report. In particular, by the end of the 75-year period, scheduled tax income would cover only one-third of projected expenditures.

The average value of the financing shortfall over the next 75 years-known as the actuarial deficit—is 1.97 percent of taxable payroll. This deficit could be closed by an immediate increase of 1 percentage point in the HI payroll tax rate, payable by employees and employers, each. (The projected deficit could also be eliminated by many other revenue increases and/or expenditure reductions.) Note, however, that such a change would only correct the deficit "on average." Initially, HI revenue

would be significantly in excess of expenditures, but by the end of the period, only about one-fourth of the projected deficit would be eliminated.

The effect of the baby boom's retirement on Social Security and Medicare is relatively well known, having been discussed at length for more than 25 years. Basically, by the time the baby boom cohorts have retired, there will be nearly twice as many HI beneficiaries as there are today. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary. As shown in chart 5, this ratio is currently 4.0 workers per beneficiary. With the advent of the baby boom's retirement, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to 2.3 in 2030 and 2.0 in 2075 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

Chart 4—Workers per HI beneficiary

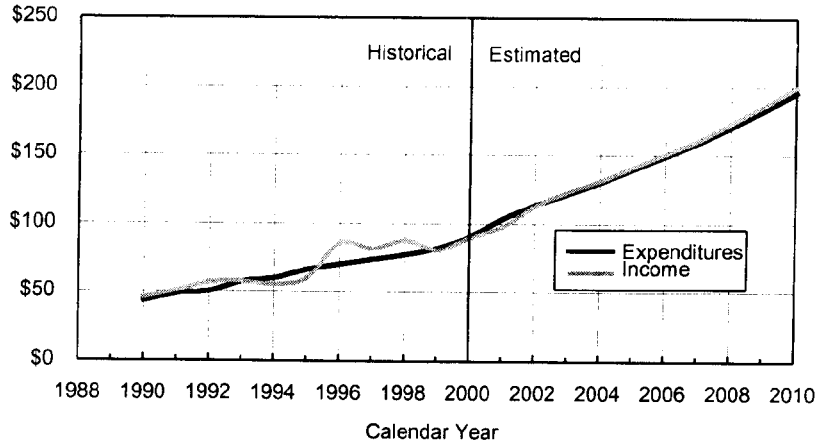


There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 17.4 years currently, with an estimated further increase to about 21 years at the end of the long-range projection period. Medicare costs are also sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than younger persons. Thus, as the beneficiary population ages over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

FINANCIAL OUTLOOK FOR SUPPLEMENTARY MEDICAL INSURANCE

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

Chart 5—SMI expenditures and income
(In billions)



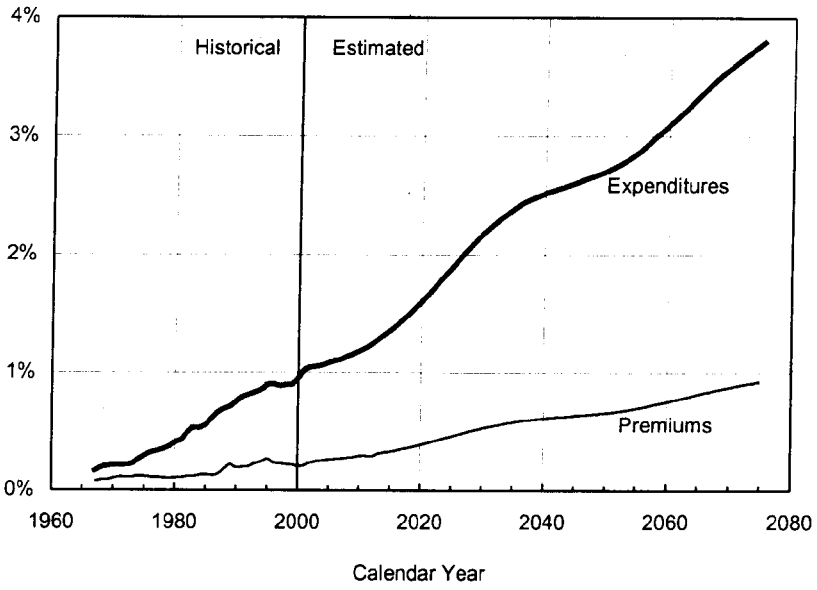
Although the Balanced Budget Act contained a number of provisions designed to reduce the rate of growth in SMI expenditures, their impact was more than offset by other factors. First, the Act specified that home health services not associated with a prior stay in an institution were to be converted to Part B benefits and paid for by the SMI trust fund (phased in over several years). In addition, the Act provides for several significant new preventive or "screening" benefits, such as colorectal examinations, not previously covered by Medicare, and it gradually corrects an excessive level of beneficiary coinsurance for outpatient hospital services. As a result, SMI costs are estimated to increase somewhat as a result of the Balanced Budget Act. Further cost increases have resulted under the Balanced Budget Refinement Act of 1999 and the Benefit Improvement and Protection Act of 2000.

Chart 6 shows projected long-range SMI expenditures and premium income as a percentage of GDP. Under present law, beneficiary premiums will continue to cover approximately 25 percent of total SMI costs, with the balance drawn from general revenues. Expenditures are projected to increase at a significantly faster rate than GDP, for largely the same reasons underlying HI cost growth. After about 2030, the SMI costs projected in the 2001 Trustees Report are substantially higher than those in the 2000 report, again primarily as a result of the revised long-range growth rate assumption recommended by the Medicare Technical Review Panel.

Although SMI is automatically in financial balance, the program's continuing rapid growth in expenditures places an increasing burden on beneficiaries and the Federal budget. In 2000, for example, about 6 percent of a typical 65-year-old's Social Security benefit was withheld to pay the monthly SMI premium of $45.50, and another 8 percent was required to cover average deductible and coinsurance expenditures for the year. Twenty years later, under the intermediate assumptions, the same beneficiary's premium and copayment costs would average 21 percent of his or her benefit.[2] Similarly, SMI general revenues in fiscal year 2000 were equivalent to 5.4 percent of the personal and corporate Federal income taxes collected in that year. If such taxes remain at their current level, relative to the national economy, then SMI general revenue financing in 2075 would represent 22 percent of total income taxes.

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

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

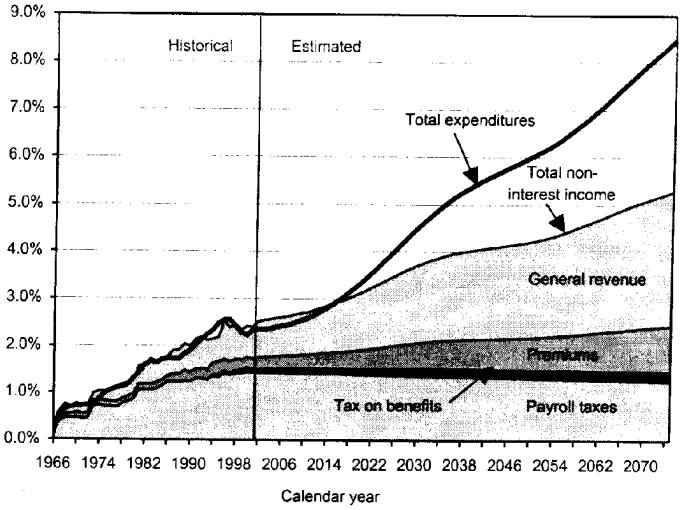


COMBINED HI AND SMI EXPENDITURES

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

Combined HI and SMI expenditures are projected to increase from 2.2 percent of GDP to about 8.5 percent in 2075, based on the Trustees' intermediate set of assumptions. In past years, total income from HI payroll taxes, income taxes on Social Security benefits, HI and SMI beneficiary premiums, and SMI general revenues was very close to total expenditures. Over the next 15 years, such Medicare revenues are estimated to slightly exceed program expenditures, reflecting the expected excess of HI tax income over expenditures. Thereafter, however, overall expenditures are expected to exceed aggregate revenues. Again, the growing difference arises from the projected imbalance between HI tax income and expenditures throughout this period, SMI revenues would continue to approximately match SMI expenditures.

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



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

CONCLUSIONS

In their 2001 reports to Congress, the Board of Trustees notes the significant improvement in the financial outlook for Medicare that has come about as a result of legislation, strong economic growth, relatively slow growth in health costs generally, and efforts to combat fraud and abuse. But they emphasize the continuing financial pressures facing Medicare and urge the nation's policy makers to take further steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future. Today's relatively favorable conditions could change, accelerating the expected return to deficits in the HI trust fund. Moreover, the earlier solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

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

RESPONSES TO QUESTIONS FROM SENATOR HATCH

Question: Mr. Foster, I appreciate your insights on the 2001 Medicare Trustees Report. I must admit that the long-range financial outlook for both the Medicare Part A program and the Medicare Part B program is disturbing. Will you please explain to me how the long-range estimates for both trust funds changed so dramatically within a one-year period?

Answer: As you note, the long-range cost estimates shown for Medicare in the 2001 Trustees Reports are substantially higher than in last year's reports. By the end of the Trustees' 75-year valuation period, both Part A and Part B expenditures are approximately 60 percent greater than previously projected.

This change resulted from the adoption of improved, more realistic long-range expenditure growth rate assumptions in the new reports. Specifically, for the 25th through 75th years of the projection, average Medicare expenditures per beneficiary

are assumed to increase at the rate of per capita GDP growth plus 1 percentage point. This assumption represents about a 1-percentage-point increase in the annual growth rate compared to the prior assumption. (Estimated demographic impacts, such as longer life expectancies, cause additional cost increases beyond this growth rate.)

The change in the long-range growth rate assumption was recommended by the 2000 Medicare Technical Review Panel, convened by the Board of Trustees to review the assumptions and methods underlying the Medicare projections in the annual Trustees Reports. The Panel consisted of 7 expert health actuaries and economists, who were nominated by the prior public members of the Board of Trustees. Such panels have periodically reviewed both the Medicare and Social Security projections for many years.

The 2000 Panel concluded that improvements in medical technology were likely to continue to contribute to increases in health spending, at about the same rate as in the past. This conclusion resulted in their recommendation to increase the long-range expenditure growth assumption. They also considered other determinants of health cost growth, the impact of managed care on such growth, other forecasts of long-range spending increases, and the eventual "sustainability" of alternative rates of growth in health expenditures.

Although the Panel acknowledged the substantial uncertainty inherent in setting such an assumption, they unanimously concluded that the available evidence supported their new recommendation much more strongly than the Trustees' previous assumption. I concurred with the Panel's recommendation, as did the Board of Trustees, and it was adopted for the 2001 Medicare Trustees Reports.

PREPARED STATEMENT OF KAREN M. IGNAGNI

I. INTRODUCTION

Good morning, Mr. Chairman and members of the Committee; I am Karen Ignagni, President and Chief Executive Officer of the American Association of Health Plans (AAHP). The members of AAHP appreciate the opportunity to testify today and assist in the Committee's deliberations on addressing the issue of outpatient prescription drugs for Medicare beneficiaries. AAHP represents more than 1,000 HMOs, PPOs, and similar network health plans; our membership includes the majority of Medicare+Choice organizations, which collectively serve more than 75 percent of beneficiaries in the Medicare+Choice program. Together, AAHP member plans provide coverage for 5.6 million Medicare+Choice beneficiaries and more than 150 million Americans nationwide. We strongly support efforts to modernize Medicare and give beneficiaries health care choices that are available to working Americans.

II. PRESCRIPTION DRUG COVERAGE IS CRITICAL TO THE MEDICARE PROGRAM

We believe that creating an affordable prescription drug benefit under Medicare is an important piece of unfinished business this Congress can and should address. In creating the Medicare program thirty-six years ago, our nation made a commitment not only to the elderly and disabled who directly benefit from the program, but also to their families whom otherwise would bear the overwhelming costs of their health care. As more prescription drugs have become available and have taken a more critical role in medical treatment, especially to the chronically ill, the absence of an outpatient prescription drug benefit in the Medicare program has become problematic for many Medicare beneficiaries and their families.

AAHP and its member plans strongly support making a well designed, flexible and financially sustainable drug benefit available to Medicare beneficiaries.

III. MANY MEDICARE+CHOICE PLANS HAVE BEEN PROVIDING PRESCRIPTION DRUG COVERAGE AND HAVE BEEN A PRIMARY SOURCE OF COVERAGE FOR VULNERABLE BENEFICIARIES

For several years now, Medicare+Choice plans and their predecessors, Medicare risk plans, have been a critical source of prescription drug coverage for many seniors and the disabled. A majority of Medicare beneficiaries without drug coverage paid for by Medicaid or by a former employer choose our plans as their source of

prescription drug coverage. Furthermore, Medicare+Choice enrollees have expressed consistently high levels of satisfaction with their plans.[1]

AAHP members stand ready to offer their knowledge and experience as Congress considers ways to provide a prescription drug benefit for senior citizens. Because Medicare+Choice plans completely integrate outpatient pharmaceutical coverage into the Medicare coverage they offer, Medicare+Choice plans are—and continue to be—well positioned to offer beneficiaries an effective coverage option.

Medicare+Choice is a Critical Source of Prescription Drugs for Low-Income Beneficiaries Without Subsidized Supplemental Coverage

While Medicaid provides coverage for the poorest beneficiaries and other beneficiaries may have supplemental insurance subsidized by a former employer, for all others, supplementing Medicare for drugs and other treatments can be prohibitively expensive, particularly for those on fixed incomes. An AAHP analysis of HCFA data from 1997 demonstrated that Medicare plans serve many financially vulnerable beneficiaries, principally those without subsidized supplemental coverage and those with limited or modest incomes who are not eligible for Medicaid.[2]

Specifically, AAHP found that nationally, 54 percent of Medicare beneficiaries with unsubsidized supplemental coverage for drugs obtained coverage through Medicare managed care plans. Results showed that Medicare managed care plans' role in making drug coverage available to beneficiaries spanned income groups, but was greater among lower income groups. Moreover, where Medicare managed care plans had a strong presence, such as in urban areas of the West and Northeast, more beneficiaries had drug coverage. For example, in urban areas of the West, 65 percent of Medicare beneficiaries without subsidized supplemental coverage had drug coverage compared with 42 percent nationally.

As further evidence of Medicare+Choice plan benefits to low-income beneficiaries, MedPAC's March 2000 Report to Congress showed that enrollees in Medicare managed care plans typically spend approximately $1,000 less annually on out-of-pocket health expenditures than those in FFS with Medigap.

Medicare+Choice Enables Affordability of Prescription Drugs

One Medicare+Choice member from Florissant, Missouri, concerned about the sustainability of the Medicare+Choice program wrote to her representative in 1999,

"I joined Medicare Complete (an HMO) because it had better coverage than Medicare. I am a diabetic and have to go to the doctor every 3 months to keep it under control. Also have some side effects, and sometimes have to see other doctors.

The prescription coverage helps to buy insulin and supplies. We seniors on limited income could not afford Medicare & pay for supplemental insurance."

Mr. Chairman, this is just one example of how important Medicare+Choice is to enrollees who rely on the program for the prescription drug coverage that they need and could not otherwise afford.

IV. MEDICARE+CHOICE ORGANIZATIONS CAN HELP CONGRESS ACHIEVE COMPETING POLICY GOALS

Members of Congress face two competing policy objectives: making a comprehensive prescription drug benefit available to Medicare beneficiaries while simultaneously controlling the program's escalating costs. Our members are well positioned to help Congress achieve its policy goals.

Medicare+Choice organizations offer the advantage of a prescription drug benefit using advanced pharmacy management techniques integrated with medical and surgical benefits. It is important to recognize, however, that even with the use of state-of-the-art pharmacy management tools pioneered by private health plans, prescription drug expenditures are escalating rapidly. To function properly in this environment, any prescription drug benefit must be backed by adequate funding that is sustained over time. Moreover, any new prescription drug program should be designed to allow for the continued evolution of pharmacy management strategies that promote affordability and accessibility of prescription drugs. Lastly, any new regulatory framework that accompanies a prescription drug benefit should pave the way for the successful implementation of the program and its evolution as the program matures.

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[1] Medicare risk and Medicare+Choice enrollees have consistently expressed overall satisfaction with their quality of care at percentage rates in the mid-to-high nineties. See MedPAC Reports to Congress dated March 2000 (p. 34) and June 1998 (p. 133).

[2] AAHP, "Financially Vulnerable Medicare Beneficiaries Rely on HMOs for Prescription Drug Coverage,' May 2000.

Medicare+Choice Offers an Important Advantage

One of the advantages of Medicare+Choice managed care plans is that they allow doctors and other health professionals to coordinate a patient's care across the full spectrum of health care services. Physicians, pharmacists, nurses and other health care providers are better able to communicate with one another and collaboratively monitor a patient's care based on current and past interactions with the medical system. In addition, properly integrating or coordinating pharmaceutical coverage with a plan's medical and surgical coverage reduces costs and maximizes care options available to the patient.

I would like to highlight three examples here.

Centralized, Electronic Record-Keeping and Coordinated Care

Many plans are using centralized, electronic recordkeeping to help physicians provide better care for their patients. For example, an increasing number of plans issue to physicians portable, hand-held interactive electronic devices that allow doctors to look up plan formularies, access physician reference materials, and review patient claims data on site, as they are treating a patient. Not only does this system allow for a more holistic approach to patient care, but it also minimizes medical errors. The device will identify potentially harmful drug—drug interactions and will allow a physician to electronically transmit prescriptions to a network pharmacy, eliminating the need for error—prone handwritten prescriptions.

Disease Management and Cardiac Care

Many AAHP member plans have focused on a coordinated approach to cardiac care. In one plan, a team comprised of a doctor, pharmacist, and nurse identify, evaluate, and implement the latest treatments that are shown to be effective. The team then shares its findings with practitioners within the health plan's individual network. A recent example was the decision by the team to double the prescribed dosage level for an ACE inhibitor given to patients with heart disease. That decision was based on a Project HOPE study of nearly 10,000 subjects from 270 hospitals. Results indicated that for every 27 patients treated with an ACE inhibitor for five years, one death from cardiovascular disease, myocardial infarction, or stroke was prevented. The system for evaluating and implementing evidence-based medicine, as recommended in the recent Institute of Medicine report, allowed the health plan to respond quickly to this breakthrough study.

In addition, the health plan employs an electronic disease registry. The registry is an effective tool for the practitioner's ability to monitor whether cardiac patients are getting the treatment they need and clearly shows whether a patient is due for a cholesterol check or has been offered the currently recommended medications. One 75-year old member of the health plan who has had two previous heart attacks remarked about his care, "I'd probably be dead if it wasn't for the type of treatments that are available these days." In this case, a heart patient directly benefited. But the applied innovations and reduced long-term costs that result from improved care benefit us all.

The Use of Formularies to Enhance Patient Care

A drug formulary or preferred drug list is a compilation of drugs that have been reviewed for safety and efficacy. Research has demonstrated that the use of formularies improve the quality of healthcare, enhance clinical effectiveness and streamline costs. For example, in a recent case involving an AAHP member plan, a request for a non-formulary oral antibiotic medication was received in the prior authorization department. The physician had prescribed this drug for a serious knee infection. When taken orally, the medicine could not get into the blood stream in a high enough concentration to effectively treat the infection. The plan's systems identified this as a quality of care issue, and the plan contacted the doctor to suggest changing the medication to an intravenous form. Notwithstanding the fact that the intravenous drug was significantly more costly than the oral medication, the latter would have had no benefit and potentially could lead to a more serious problem, including the need for surgery.

Mr. Chairman, these are but three examples of the benefits, both medical and fiscal, that can accrue to the nation if the Medicare+Choice organizations' approach to integrated prescription drug coverage for their Medicare beneficiaries is allowed to grow.

A Medicare Prescription Drug Benefit Should Promote Effective Pharmacy Management Techniques

Our health plans have pioneered the development and application of tools that achieve high quality patient care while maintaining cost efficiencies. Managed care has developed or adapted many techniques to deliver pharmacy services to help im-

prove drug therapy care, while at the same time focusing on health care costs. As Congress works to achieve balance between its two policy goals, any proposed drug plan should promote the use of advanced pharmacy management techniques such as:

- **Formulary management.** A drug formulary is a mechanism for selecting safe, effective, affordable medications that maintain or improve patient care. Tiered formularies, an innovation recently developed by private plans, offer consumers coverage of a broad array of prescription drugs while varying cost sharing based on the consumers' choice. Additionally, formularies promote quality care by fostering the use of those drugs deemed to be safe and effective by physicians, pharmacists and other medical experts. Formularies often contain prescribing and clinical information to help health care professionals promote high quality care. A recent research article reported that "ineffective or unsafe medications were prescribed less often in Medicare HMOs [which use formularies] than in national comparison groups. In fact, for the elderly who are most at risk, the use of these medications was much lower in the Medicare HMO than in the Medicare fee-for-service sector."[3]
- **Generic substitution programs.** Generic drugs offer equivalent therapeutic benefits and normally are less expensive than brand-name drugs. Consumers generally pay 30 percent to 50 percent less when purchasing generic drugs than when purchasing equivalent brand-name drugs. In 1998, generic drugs accounted for 46 percent of all prescriptions dispensed in the United States; but because they are less expensive, generics represented only 8 percent of total prescription drug sales.[4] The ability to substitute generic medicines is an effective way to provide a variety of prescription drugs to beneficiaries at a lower cost.
- **Step therapy.** Step therapy involves prescribing successive drug regimens to be taken in an attempt to control a disease or condition. Step therapy specifies which drugs should be taken at each stage of treating the patient. "First step" drugs usually are the most common approach to treating a patient's condition. If the patient does not improve, the next step in therapy is initiated. For example, if lifestyle modifications and an anti-hypertensive drug do not adequately control a patient's high blood pressure, another drug will be added or substituted based on clinical guidelines and the judgement of the health care professional. The patient's blood pressure is monitored to ensure that it is under control. Generally, more complex drug regimens are used after simpler regimens have proved ineffective. Step therapy has been proposed by prominent organizations such as the National Heart, Lung, and Blood Institute of the National Institutes of Health.
- **Integrated retail and mail service for home delivery.** Many health plans make available integrated mail service programs to enhance the convenience for beneficiaries, particularly for the frail elderly and the disabled who may lack the mobility to purchase their prescriptions at the local pharmacy. For beneficiaries receiving maintenance drugs to treat chronic disease, mail service programs are an important component in ensuring proper drug utilization. Beneficiaries also save money when using mail service through lower co-payments.

The Experience of the Medicare+Choice Program Illustrates the Need for a Sufficient, Reliable Source of Funding

With the passage of the Balanced Budget Act of 1997 (BBA) Congress took significant steps toward the goals of: (1) providing Medicare beneficiaries with expanded choices similar to those available in the private sector; 2) extending the solvency of the Medicare Trust Fund. AAHP supported the BBA and regarded it as the foundation for moving forward with a program design that could be sustained far into the future. Unintended consequences of the BBA, however, resulted in beneficiaries losing extra benefits and, in many instances, the option of even remaining in the plan of their choice.

Both the Balanced Budget Refinement Act (BBRA) and the Benefits Improvement Protection Act (BIPA) were important steps by Congress to correct these unintended consequences. With BBRA, the phase-in of HCFA's risk adjuster was slowed and beneficiary information campaign user fees were fairly apportioned, among other changes. BIPA made additional improvements by increasing payments to rural and

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[3] Futterman et al, "Use of Ineffective or Unsafe Medications Among Members of a Medicare HMO Compared to Individuals in a Medicare Fee-for-Service Program," *American Journal of Managed Care*, April 1997.

[4] National Institute for Health Care Management, "Factors Affecting the Growth of Prescription Drug Expenditures," Barents Group, LLC, July 9, 1999.

some urban areas and providing a one-time increase in the minimum update. As a result, Medicare+Choice plans have been able to resume service in a few counties, reduce premiums or enhance benefits for enrollees, and have stabilized their provider networks.

But the lessons learned in the Medicare+Choice program are sobering. As effective as Medicare+Choice plans can be at delivering pharmaceuticals as part of a Medicare benefit, neither they, nor any plan can succeed without a sufficient and reliable source of funding. We are deeply concerned that the administrative and regulatory actions taken by HCFA, together with the unintended results of the BBA formula, have undermined the program's stability.

Rather than enjoying expanded coverage choices as planned under BBA, beneficiaries face fewer coverage choices. Additional benefits offered by plans that are not available in the fee-for-service program—especially prescription drugs—are being jeopardized. Some Medicare+Choice enrollees who once enjoyed robust prescription drug benefits have seen those benefits reduced over time through higher cost-sharing and lower spending caps. Payment and regulatory requirements dictate the environment in which health plans operate if they choose to participate in the Medicare+Choice program. The current payment and regulatory environment has forced many plans to make difficult decisions regarding their participation in the Medicare+Choice program.

Nevertheless, Medicare+Choice plans stand willing and ready to participate in a well-designed Medicare drug program that has adequate and stable funding over time. AAHP urges the Congress to consider carefully the methodology it may use to fund the benefit, especially in light of recent reports by the Congressional Budget Office that have suggested a comprehensive prescription drug benefit for the Medicare program may be more expensive than many thought it would be.

Regulatory Framework Should Pave the Way for Successful Implementation

As the Administration and Congress consider options for adding prescription drugs to the Medicare program, it is critically important that such a benefit be administered efficiently and effectively. The regulatory framework should be designed to promote, rather than impede, the implementation of the prescription drug benefit.

Medicare+Choice has the potential to serve as a foundation for the Medicare program of the future. With its focus on beneficiary choice and private sector participation, the Medicare+Choice program is designed to offer Medicare beneficiaries the same health care options that are available to Americans who obtain their health coverage through the private sector. Unfortunately however, the Medicare+Choice program has been undermined by a misguided approach to administering and regulating the program. Rarely are the costs of regulatory requirements measured in comparison to their benefits, forcing health plans to spend scarce resources on compliance activities of questionable value—leaving plans with fewer resources to spend on patient care.

To create a pathway that promotes implementation of a prescription drug benefit and fosters participation by private sector health plans, HCFA should:

(1) Consolidate its complex and fragmented policy making process;
(2) Enable timely decision-making by simplifying it's review process;
(3) Establish and work towards achieving program-wide priorities;
(4) Streamline program oversight and reduce unnecessary administrative burdens; and
(5) Provide for consistency between HCFA Central and Regional offices.

VI. AAHP SUPPORTS CONGRESSIONAL EFFORTS TO PROVIDE A MEDICARE PRESCRIPTION DRUG BENEFIT

The American Association of Health Plans (AAHP) and its member plans stand ready to contribute as the Committee continues its deliberations on the best way to expand access to affordable prescription drug coverage. We have tried today to contribute to the Committee's dialogue and pledge further assistance on the issues of expanding prescription drug coverage, broader Medicare reform, and the need to preserve the Medicare+Choice program as an important gateway towards achieving these objectives.

Medicare+Choice plans have an important role to play as Congress evaluates how best to provide Medicare beneficiaries with access to prescription drugs. Our knowledge and experience in designing and implementing valuable pharmacy benefit programs can serve as a foundation for reform. Our members support Congress' efforts to provide prescription drug coverage for Medicare beneficiaries. We thank you for the opportunity to testify.

PREPARED STATEMENT OF PATRICIA NEUMAN, SC.D.

Thank you, Mr. Chairman and Members of the Committee, for the opportunity to testify on efforts to improve prescription drug coverage for Medicare beneficiaries. I am Patricia Neuman, a vice president of the Kaiser Family Foundation and Director of the Foundation's Medicare Policy Project. I am also an associate faculty member in the Department of Health Policy and Management at The Johns Hopkins University School of Hygiene and Public Health.

By many measures, Medicare has been and continues to be one of the nation's most successful federal programs. Medicare has provided a vital source of health coverage for elderly and disabled Americans, a population that faced significant difficulties obtaining health insurance before Medicare was created. Since its enactment in 1965, Medicare has been reformed incrementally over time to address many critical problems as they have emerged. Due to changes in Medicare payment systems, for example, Medicare has been at least as effective as the private sector in controlling the rise in health care spending over time. Perhaps most importantly, Medicare's successes can be measured by the broad popular support it enjoys among both the general public and the high level of satisfaction reported by its beneficiaries.

Of course, Medicare continues to face challenges that will need to be addressed through ongoing reforms. Over the long term, the greatest challenge will be to finance care for an aging population that will double in size over the next 30 years. This will require an infusion of revenues in addition to the new funds that would be needed to pay for the addition of a new drug benefit. Improvements are also needed to stabilize the Medicare+Choice program, to help Medicare become a more fair and reliable business partner for health providers and plans, and to ensure the program evolves with advances in medical practice.

From the beneficiary perspective, however, no problem is more pressing than filling one of the primary gaps in Medicare's benefit package with affordable prescription drug coverage. Today, in the presence of a federal budget surplus, a bipartisan commitment to addressing this problem, and public support for a Medicare prescription drug benefit, this appears to be an historic window of opportunity to take on this policy challenge. My testimony today begins with a brief review of existing sources of prescription drug coverage and a discussion of why coverage matters. It then reviews efforts to improve coverage, identifying both significant areas of common ground and key policy issues and challenges, and their budgetary implications.

WHO LACKS PRESCRIPTION DRUG COVERAGE?

According to data released just last week, more than 10 million beneficiaries—accounting for more than a quarter of the Medicare population—lacked prescription drug coverage throughout 1998, the most recent year for which data are available. This number masks the much larger share of beneficiaries—about one-half—who were without continuous coverage at some point over the course of that year. Lack of coverage disproportionately impacts those who are low-income, living in a rural area, and among the oldest-old (ages 85 and older).

The absence of drug coverage affects beneficiaries of all income levels. Half of all beneficiaries without drug coverage have an income above 175 percent of the federal poverty level (above $14,600 for an individual in 2000) (Exhibit 1). Still, it is the near-poor (those between 100–175 percent of the poverty level) who are the most likely to be without drug coverage because their incomes and assets tend to exceed the levels necessary to qualify for Medicaid, but still leave them unable to purchase a Medigap policy with drug coverage easily on their own (Exhibit 2). More than 30 percent of beneficiaries with incomes between 100 and 175 percent of poverty lacked drug coverage in 1998, compared with 23 percent of those with incomes above 300 percent of poverty, and 27 percent of those with incomes below poverty.

Beneficiaries living in rural areas are more likely than those living in other areas to lack drug coverage. Nearly four in ten beneficiaries living in rural areas (37 percent) lack drug coverage, compared to 23 percent of those in metropolitan areas (Exhibit 3). These beneficiaries are both less likely to have been in jobs that offer retiree health benefits and to have access to a Medicare managed-care plan. Only 14 percent of rural beneficiaries have a Medicare+Choice plan in their region, explained in part by the difficulties of establishing plans in these areas.

Medicare's oldest-old are significantly more likely than younger beneficiaries to go without drug coverage-despite the need for multiple medications that often comes with advancing age and multiple chronic conditions. More than a third of those ages 85 and older (34 percent) were without coverage in 1998 compared to 25 percent of those between ages 65 and 74. This lack of drug coverage comes at a time when

seniors' retirement savings are often insufficient to help them afford expensive medications.

WHAT IS THE CURRENT STATE OF PRESCRIPTION DRUG COVERAGE?

While an estimated 73 percent of beneficiaries had some form of drug coverage for at least part of the year in 1998, such coverage is often inadequate and, for many, likely to decline in the near future. Beneficiaries today rely upon a range of sources for help with the cost of their medications, including employer-sponsored retiree coverage, individually purchased Medigap policies, Medicare managed-care plans, the Medicaid program, and—in some states—state-operated pharmacy assistance programs. Although these sources have helped to fill Medicare's gaps and shield seniors from high out-of-pocket costs, access to such coverage is increasingly limited and expensive.

Employer-sponsored plans, the leading source of drug coverage for seniors, provided relatively comprehensive drug benefits to nearly 33 percent of the Medicare population in 1998. There is some concern, however, that reductions in drug benefits for retirees are on the horizon. Forty percent of large employers say they are seriously considering cutting back on drug benefits for their retirees in the next three to five years, according to a recent survey of large employers conducted for the Kaiser Family Foundation by Hewitt Associates (Exhibit 4). Further, with the share of large employers offering health benefits to retirees over age 65 declining from 80 percent in 1991 to 66 percent in 1999, today's workers are less likely than current retirees to receive drug benefits from their employers when they retire.

Individually purchased Medigap policies have been another source of prescription drug coverage for the Medicare population. The premiums for these policies, however, are rising rapidly—by as much as 20 to 30 percent in many markets—and now range from about $1,400 to $4,700 per year, depending on where beneficiaries live, the type of coverage they obtain, and their age. As a result, only 9 percent of all beneficiaries with a standard Medigap policy-accounting for less than 2 percent of the entire Medicare population—have a standard Medigap plan that includes drug coverage (Exhibit 5). Access to Medigap drug coverage is further restricted by rules permitting insurers to deny Medigap drug coverage to many under-65 disabled Medicare beneficiaries and to others who lose coverage upon disenrolling from an HMO.

Medicare HMOs were, until recently, a promising source of prescription drug coverage, assisting 15 percent of all beneficiaries with their drug costs in 1998. There is much uncertainty, however, about the future role of Medicare+Choice plans as a source of prescription drug coverage. In recent years, the number of plans participating in the Medicare+Choice program has declined, as have both the number of plans offering drug benefits and the level of drug coverage offered. (Exhibit 6). As a result, 22 percent of Medicare HMO enrollees had no drug coverage in 2000 and another 25 percent had a drug benefit of $750 per year or less (Exhibit 7).

For those with low incomes, Medicaid is a critical source of drug coverage, most notably those receiving cash assistance through the Supplemental Security Income (SSI) program and those living in nursing homes. Although states are not required to provide drug coverage under Medicaid, all include it as part of their Medicaid benefits package. More than 5 million (12 percent) community-based Medicare beneficiaries were enrolled in Medicaid in 1998, most of whom (89 percent) received prescription drug coverage from this source. It is important to note, however, that only about half of all beneficiaries living below the poverty level received any assistance from Medicaid (Exhibit 8).

Many states are now struggling with the budgetary impact of prescription drug costs. Medicaid payments for outpatient pharmaceuticals rose from an estimated $5 billion in 1990 to $17 billion in 1999, at an average annual increase of almost 15 percent. This growth stemmed largely from rising costs for the disabled and elderly, who accounted for 80 percent of all Medicaid prescription drug spending in 1998 (Exhibit 9). States already have some ability to limit the costs of their Medicaid drug benefits through the drug rebate program, which uses the government's volume purchasing authority to obtain discounted prices. States are also adopting additional strategies to control the rapid growth in pharmacy spending, by limiting the number of prescriptions covered per month, seeking larger discounts from manufacturers, restricting access to expensive brand-name drugs, and proposing that local pharmacies lower their prices. In sum, states are looking to restrain—rather than expand—their Medicaid coverage of prescription drugs.

Finally, some states (26 as of January 2001) have enacted state-based pharmacy assistance programs to assist seniors on fixed incomes. Combined, these programs assist an estimated one million individuals, the majority of whom are concentrated

in three states. As with Medicaid, these programs vary widely in terms of structure, eligibility, and benefits. While most provide a direct subsidy to low-income seniors, other approaches include discount programs, tax credits, and private-insurance models. Most are relatively new and not widely utilized.

In sum, while a patchwork of alternative sources of prescription drug coverage may compensate, in part, for the absence of a Medicare prescription drug benefit, both the generosity and the reliability of each of these sources are increasingly questionable in today's environment. Given these trends, there is concern that the number of those without drug coverage will rise, along with the number of those who are underinsured for the costs of their prescription medications.

WHY IS DRUG COVERAGE IMPORTANT?

Prescription drug coverage matters to people of all ages, but it is especially important to the sick and chronically ill who are disproportionately represented among the elderly and disabled on Medicare. Seniors are more likely than younger adults to have multiple acute and chronic conditions typically treated with medications, which explains why drug use increases dramatically with age. Those ages 65 to 74, for example, fill on average 20 prescriptions per year, compared with an average of 5 prescriptions filled by those between the ages of 19 and 44 (Exhibit 10).

The need for prescription drugs often comes at a substantial cost to the Medicare population—a population that generally lives on fixed incomes. Forty percent of all Medicare beneficiaries—14 million people—have incomes below 200 percent of poverty, or below $16,500 for an individual (Exhibit 11).

Given the key role of pharmaceuticals in medical care today, those without drug coverage are basically uninsured for what may arguably be the most critical component of their medical treatment. In addition, there is a growing body of research documenting the widening gap between the haves and the have-nots. Beneficiaries without drug coverage filled 8 fewer prescriptions per year on average than those with coverage in 1998. Even more striking, beneficiaries in poor health without drug coverage averaged 15 fewer medications than their insured counterparts (Exhibit 12).

There is also anecdotal evidence of beneficiaries misusing drugs because they cannot afford to take their medications as prescribed by their doctor, by skipping doses, splitting pills, and sharing medicines with friends or family members. Systematic underutilization of prescribed medications poses a threat to quality of care and potentially increases costs to the system in terms of avoidable emergency room and hospital admissions, physician visits, and nursing home stays.

Beneficiaries without drug coverage also incurred higher out-of-pocket costs in 1998, spending on average $221 more than beneficiaries with drug coverage ($546 vs. $325). Among those in poor health, the disparities in out-of-pocket spending widened between those who lacked coverage and those with coverage ($820 vs. $490) (Exhibit 13).

Beneficiaries without drug coverage incur relatively high costs both because they do not have an insurer to share the cost of each prescription and because they often pay the full retail price when they go to the pharmacy. By contrast, those with prescription drug coverage are often shielded from the full effect of high and rising drug costs as they may benefit from pharmacy discounts negotiated by their employer-sponsored plan or HMO.

The predicted rise in drug expenditures will likely compound these concerns. Since 1990, national drug spending has almost tripled from $40 billion to an estimated $117 billion in 2000 and will, according to both the Congressional Budget Office and the Health Care Financing Administration, rise at an even more rapid rate in the next decade. In addition, spending on prescription drugs has grown more rapidly other services, including physician, hospital, and nursing home care (Exhibit 14). If, as expected, employers, Medicare+Choice plans, and states look to limit their financial liability for drug spending, the financial burden will likely be shifted directly to Medicare's elderly and disabled, who could face dramatic increases in drug costs.

EFFORTS AND OPPORTUNITIES FOR EXPANDING PRESCRIPTION DRUG COVERAGE

There are now three general approaches at the forefront of the national policy debate on improving prescription drug coverage for all Medicare beneficiaries. Drawing on models introduced during the last Congress, these include: an integrated Medicare drug benefit that would be administered by private entities, such as pharmacy benefit managers; a Medicare drug benefit that would be offered along with other benefits through high-option plans, as part of a broader framework for reform; and a stand-alone Medicare drug benefit that would be offered by private plans.

In addition to these efforts to provide a universal Medicare prescription drug benefit, the President has proposed the Immediate Helping Hand program that would assist beneficiaries with low incomes (below 175 percent of poverty) and those of all income levels with high out-of-pocket prescription drug expenses (above $6,000) through a new block grant to the states. This is proposed as an interim measure—in anticipation of enacting universal access to drug coverage as part of more comprehensive Medicare reforms.

Viewed together, these plans reflect a range of philosophical perspectives and policy priorities and illustrate difficult tradeoffs that policymakers face in designing a Medicare prescription drug benefit. A review of these proposals also reveals significant areas of apparent agreement among them.

KEY SIMILARITIES

Recognizing the Need to Help Beneficiaries Who Lack Meaningful Drug Coverage. For the first time in many years, there now appears to be a growing consensus on the need to help all beneficiaries with prescription drug expenses, rather than targeting benefits to those with low incomes or catastrophic expenses. There are, of course, important differences among proposals that would have a significant impact on both the number of people who would get drug coverage and the level of that coverage, but the rhetoric of the debate appears to be converging on the need for a universal approach.

Protecting Low-Income Beneficiaries. Virtually every major proposal recognizes the need to provide additional protections for low-income beneficiaries. Many would provide full premium assistance to the lowest-income beneficiaries (with incomes below 135 percent of poverty) and partial premium assistance to those with incomes up to 150 percent of poverty, with some offering assistance to those with incomes up to 175 percent of poverty. In addition to premium assistance, many of the leading proposals would assist low-income beneficiaries with cost-sharing requirements.

Most plans would rely upon states to administer additional benefits to the low-income population, and many would require states to use asset tests to determine eligibility for benefits (at less than twice the limit permitted for SSI). Based on the experience of the Qualified Medicare Beneficiary Program, this approach could pose significant barriers for individuals applying for the program, potentially resulting in lower participation rates.

Providing Protection Against Catastrophic Drug Expenses. Several leading proposals would aim to assist beneficiaries with catastrophic prescription drug expenses. Catastrophic protection, sometimes referred to as "stop-loss," helps protect the relatively small share of beneficiaries with high-end drug expenditures. While proposals differ in terms of the threshold amount above which expenses would be covered (i.e., $4,000 vs. $6,000) and how that amount would grow over time, there appears to be recognition of the special needs of those with extraordinarily high drug expenses.

Establishing a Voluntary Benefit. Virtually all of the current proposals would allow beneficiaries to take advantage of the new prescription drug benefit on a voluntary basis. Those satisfied with their existing coverage (from a former employer, for example) would not be required to enroll in the new program, nor would they be forced to pay for a benefit, unless they elected to receive it. The decision to make the benefit voluntary reflects one of the chief lessons learned from the ill-fated Medicare Catastrophic Coverage Act (MCCA) of 1988.

Distancing Government from Direct Drug Pricing. Marking another major departure from the MCCA, none of the current proposals for improving coverage advocates the use of a government-administered pricing system. Instead, they tend to delegate cost-management decisions to risk-bearing private plans or to other private entities such as pharmacy benefit managers (PBMs).

Maintaining a Role for Employers. Acknowledging the key role that employers play in financing prescription drug coverage for retirees and the trend toward eroding employer-sponsored drug coverage, many proposals would offer financial incentives to encourage some level of continued employer-based drug coverage.

POLICY CHALLENGES

Despite the many important areas of agreement, there remain a number of difficult decisions and policy challenges that have implications for both beneficiaries and program costs.

What strategies should be used to reach beneficiaries without drug coverage? One of the major challenges is designing a program that will reach the largest number of beneficiaries who lack drug coverage, including those who live in rural areas, those who have modest and low incomes, and those who are frail or among the old-

est-old. This means developing an approach that can adapt to highly variable local markets and health delivery systems, that is available everywhere, that is affordable, and that is relatively user-friendly given the vulnerabilities in this population.

Making coverage available. One of the key issues is ensuring that Medicare drug benefits are available to those who live in all parts of the country. Despite differences pertaining to the desirable size of traditional Medicare and the role of competitive private plans, one of the major policy challenges is finding a way to deliver drug benefits to those in the traditional fee-for-service program, recognizing both the sheer number of beneficiaries covered under the traditional program today (86% of all beneficiaries) and the challenge of delivering benefits through private plans in difficult-to-serve areas. The recent withdrawal of many Medicare HMOs, which disproportionately affected non-urban areas, underscores the need to provide a reliable, stable source of drug coverage—that can withstand the swings of private plans' participation decisions and that will work for beneficiaries no matter where they live, or what plans are offered in their area.

Some proposals would make the prescription drug benefit available through both traditional Medicare (administered by private plans) and Medicare+Choice plans. As with other benefits covered by Medicare today, this approach guarantees benefits, whether the beneficiary lives in Miami or Manchester. Others would rely on subsidized private plans to offer drug benefits, and give the Secretary authority to assure that there is a fall back for beneficiaries in areas where private plans are not available. The latter strategy provides less clarity about how drug benefits will be provided to beneficiaries living in areas where private plans are less likely to be present, or where plan turnover is a problem.

Making coverage affordable. A second key decision that will affect participation is the level of premium subsidies. Decisions about premium subsidy levels will have a direct impact on both the number of beneficiaries expected to gain drug coverage and program spending. The willingness of beneficiaries to pay a premium (and participate in the new drug program) will be directly related to their perception of the value of the benefit. Previous CBO estimates indicate that, all things being equal, higher subsidy levels are likely to result in more beneficiaries getting drug coverage. There appears to be agreement across proposals to provide general premium subsidies, although the level of the subsidy ranges from 25 to 55 percent of the drug costs covered under the plans.

Premium subsidies are also necessary in a voluntary program to avoid selection problems, given concerns that beneficiaries with low drug costs will not sign up if premiums are too high, while those with predictably high drug costs will be more likely to do so, ultimately resulting in higher costs for all. Subsidies are viewed as a means of encouraging those with relatively low drug costs to enroll, guarding against such problems.

Making coverage user-friendly. A third critical factor in helping the largest number of people is making the program "user-friendly" and easy to navigate to accommodate the growing share of beneficiaries who will be among the oldest-old, those with diseases such as Alzheimer's, and others with frailties and disabilities. Medicare is popular among beneficiaries today, in part because obtaining coverage requires relatively few transactions. Seniors are automatically covered when they turn 65 if they are on Social Security. Payments are automatically deducted from Social Security checks, so seniors don't have to remember to write a check each month. The easier it is for beneficiaries to sign up for prescription drug coverage, pay their monthly premiums, and stay covered, the more likely they are to do so.

How should benefits be structured? The design of the Medicare benefit will also influence the extent to which the plan shields beneficiaries from rising drug costs, the level of program spending that will be required, and the rate at which spending will grow over time.

One of the key decisions is whether prescription drugs should be offered as a defined, uniform benefit or as a benefit valued at a specific dollar amount. The rationale for using an actuarially defined value is that it gives plans maximum flexibility to adapt benefit packages to changing drug technologies and changes in health-care delivery more broadly. It can also be a strategy for explicitly limiting the government's financial liability for drug expenses. The chief downside, however, is the potential for selection problems resulting from plans modifying benefit packages to attract healthier and lower-cost enrollees. There is also concern that a specified dollar approach, if not indexed to grow with the rise in drug spending, would diminish the value of the benefit and shift costs to beneficiaries over time. A further issue, and one that would make the new drug benefit different from all others that are covered by Medicare, is that drug benefits could vary across plans, and across markets, potentially creating fairness concerns and confusion for beneficiaries.

Among proposals that specify a uniform benefit, there are many important decisions regarding deductibles, cost-sharing and benefit levels, and catastrophic protections.

- Deductibles: Most would impose an annual deductible for drug benefits (*$250).*
- Benefit levels and cost-sharing: Many would impose 50% co-insurance on drug expenditures up to a specified amount (*$2,100). A modification of this approach would reduce the level of co-insurance from 50% to 25% as the beneficiary's level of drug expenditures increases.*
- The "Hole in the Donut": Many proposals would cover expenses up to a specified amount, but leave a gap in coverage between the benefit limit and the level of drug expenditures required to qualify for catastrophic protection.
- Catastrophic protection: Virtually all plans would assist beneficiaries with extraordinary drug costs, but they differ in both the level above which such coverage would begin (i.e., $4,000 vs. $6,000) and the means by which this amount would be indexed over time.

Each of these decisions could have significant implications for the number of people who are helped by the new program, the extent to which the new program shields beneficiaries from high out-of-pocket spending for prescription drugs, and for program spending.

What are the key strategies for controlling costs? Given the projected rise in drug expenditures, all of the major proposals face difficult decisions about how to control Medicare spending for this new coverage without compromising the capacity for research and development. In the past five years alone, average per capita prescription drug expenditures for Medicare beneficiaries have basically doubled. According to the latest CBO numbers, drug spending will rise at an even more rapid rate over the next decade, due to increases in drug prices, increases in utilization, and the introduction of new, higher priced drugs.

Most Medicare prescription drug proposals would rely on the private sector to help control spending. Some would give risk-bearing private plans (such as HMOs) responsibility for managing the new drug benefit. Others would have Medicare contract with private entities, such as pharmacy benefit managers (PBMs), to manage the drug benefit, following the practice of employers and many health plans in the private sector today. PBMs use a variety of strategies to influence drug use and spending. Typically, they negotiate discounts with pharmaceutical manufacturers, pharmacies, and mail-order firms; establish formularies; develop utilization review procedures; and work with their clients to develop cost-sharing structures that encourage generic substitution and the use of lower-cost brand name drugs.

The capacity of PBMs and other private entities to influence Medicare drug spending, however, will be directly related to how much authority they are given to use the tools that appear to be working in the private sector. For example, some proposals would give beneficiaries access to non-formulary drugs, provided their physician certifies the drug is medically necessary. Others would make it more difficult for beneficiaries to access non-formulary drugs without going through an appeals process. The Medicare drug proposals now under consideration differ in the extent to which they would permit PBMs and other plans to use these types of tools, and these decisions could have a significant impact on access and savings.

Who should be at risk for the cost of a new drug benefit? Related to the issue of cost-containment is the extent to which proposals rely on risk-bearing plans, rather than non-risk bearing entities such as PBMs, to manage drug benefits and control costs. The strategy of having private plans assume full risk for a drug benefit would limit the federal government's liability for drug expenditures and distance the government from decisions involving price. However, as noted by the insurance industry in testimony last year, insurers may be reluctant to assume the full risk of a new drug benefit, posing uncertainties in terms of access for beneficiaries in the absence of a clearly defined fall-back plan. To address this concern, some would have the federal government assume partial risk, through reinsurance, in the form of subsidies to private plans with high cost enrollees.

An alternative approach would have the government assume full risk, paying private entities, such as PBMs, a fee for managing benefits and costs. This approach follows the lead of the private sector in controlling drug costs, by relying on entities that already have an infrastructure in place for managing a drug benefit. A modification of this approach would have PBMs assume partial risk, providing a stronger incentive for such entities to achieve savings.

How should the new benefit be administered? As prescription drug benefits are often discussed within the context of broader Medicare reforms, proposals for improving coverage offer a range of strategies for administering this particular benefit. Some plans advocate preserving HCFA's existing administrative authority, while others propose the creation of an independent entity responsible for the administra-

tion and oversight of M+C plans and private plans offering the drug benefit or—more broadly—of all plans, including the traditional Medicare program. Under the latter approach, an independent agency could govern everything from competition among both traditional and private plans to beneficiary enrollment, education, and outreach.

There are a number of questions to consider regarding the administration of a new drug program, some of which depend on the extent of other reforms under consideration. For example, what operational changes are needed to make the program as user-friendly as possible for beneficiaries? Would a new agency eliminate concerns about HCFA's ability to be a fair and impartial manager of both fee-for-service and managed Medicare, or add inefficiency, bureaucracy, and confusion for beneficiaries? Are there functions that should be out-sourced or delegated? For example, would it make sense to have an independent outside entity advise the Secretary on the classes of drugs that should be covered by all plans, as is suggested under one of the leading proposals?

CONCLUSION

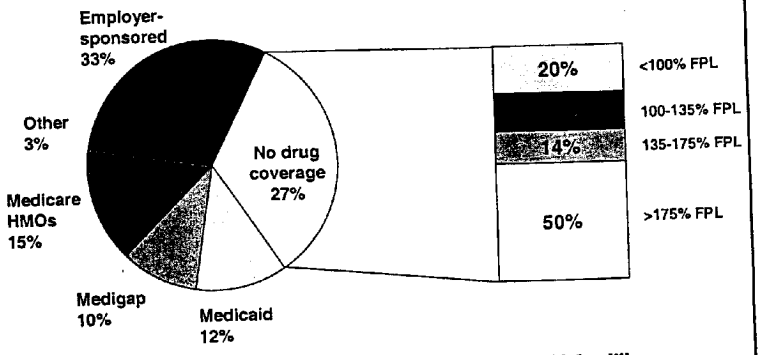
Today's 40 million Medicare beneficiaries are disproportionately likely to suffer an array of chronic health conditions now treatable with prescription medications. The range of proposals currently under consideration for improving prescription drug coverage is a promising sign that the needs of this population could soon be addressed. While there are differences among these proposals, they also reflect a significant amount of common ground.

These policy issues are set within the broader context of the debate over whether a prescription drug benefit should be enacted before consensus is achieved on more comprehensive reforms, and the debate over how much money should be dedicated to a new drug benefit versus other national priorities. Decisions regarding spending for a new drug benefit will clearly impact both the number of people who receive help and the level of assistance they receive.

This appears to be an historic window of opportunity for addressing the prescription drug needs of people on Medicare. There is widespread agreement on this problem, apparent bipartisan interest in arriving at a solution, and strong public support for action. There is also a large federal budget surplus that would greatly facilitate the financing of what promises to be an expensive addition to the Medicare program. The decisions made by this Congress could significantly improve prescription drug coverage for Medicare beneficiaries.

Exhibit 1

One-quarter of all Medicare beneficiaries lack drug coverage, about half of whom are low-income



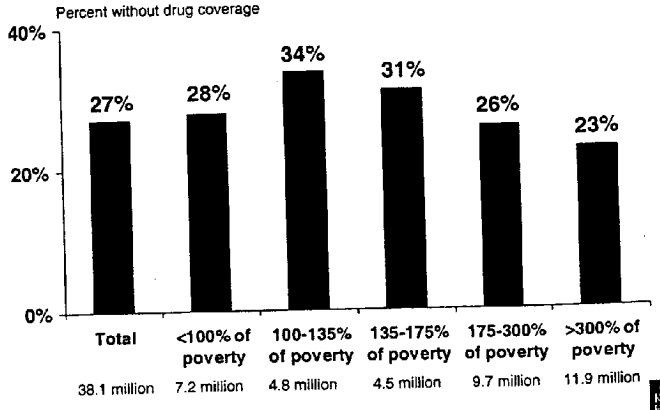
Total = 38.1 million beneficiaries

Total = 10.3 million beneficiaries without drug coverage

Note: Data are based on the noninstitutionalized population.
SOURCE: Poisal, J.A., and L. Murray, *Health Affairs*, March/April 2001.

Exhibit 2

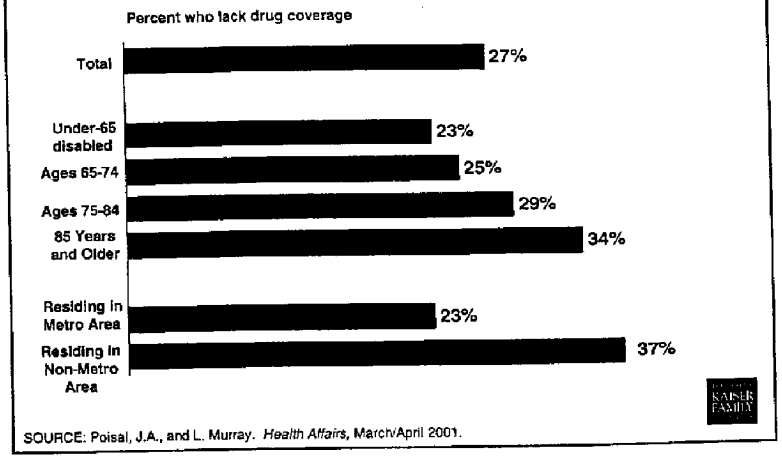
The near-poor are most likely to lack drug coverage



Note: 1998 federal poverty level was $8,050 for individuals; $10,850 for couples.
SOURCE: Poisal, J.A., and L. Murray, *Health Affairs*, March/April 2001.

Exhibit 3

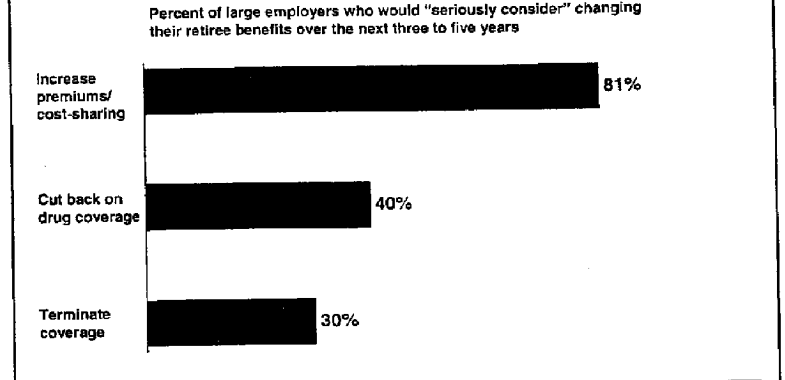
The oldest-old and those living in rural areas are most likely to lack prescription drug coverage



SOURCE: Poisal, J.A., and L. Murray. *Health Affairs*, March/April 2001.

Exhibit 4

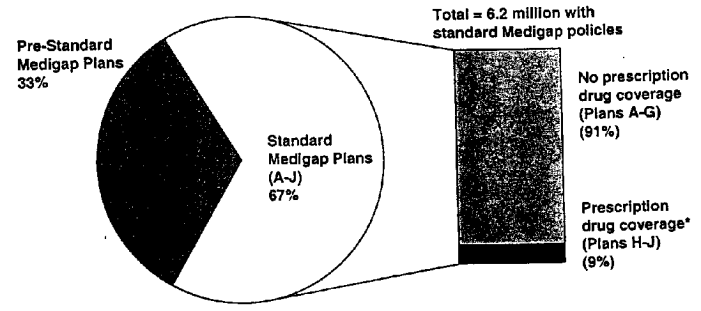
Employer-sponsored retiree health coverage is expected to erode in the near future



SOURCE: "The Implications of Medicare Prescription Drug Proposals for Employers and Retirees." Report prepared by Hewitt Associates for The Henry J. Kaiser Family Foundation, July 2000.

Exhibit 5

Medigap provides prescription drug coverage to 9% of Medicare beneficiaries with standard policies



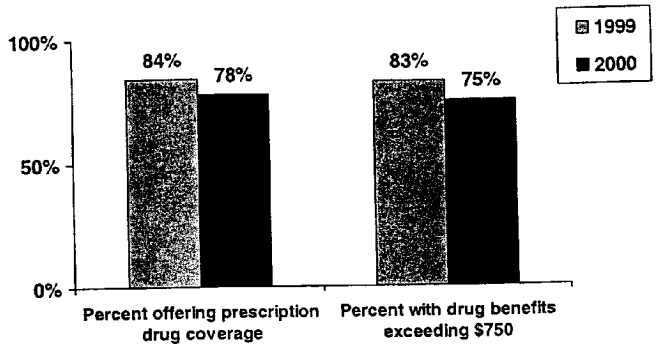
Total = 9.3 million Medigap policy owners, 1999

* For example, Plan I's drug benefit includes a $250 deductible, 50% co-insurance, and is capped at $1,250 per year.
SOURCE: Chollet, D., and A. Kirk. "Medigap Insurance: Industry Structure, Change, and Implications for Medicare." Report to ASPE, DHHS (January 2001).

KAISER FAMILY

Exhibit 6

Prescription drug benefits offered by Medicare+Choice plans declined between 1999-2000

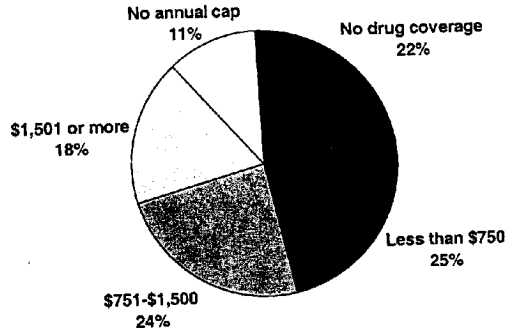


SOURCE: Mathematica Policy Research, Inc., analysis of Medicare Compare database 2000 for The Commonwealth Fund. (Benefit caps apply to prescription drug benefits in basic plans.)

KAISER FAMILY

Exhibit 7

Many Medicare HMO enrollees have limited prescription drug benefits

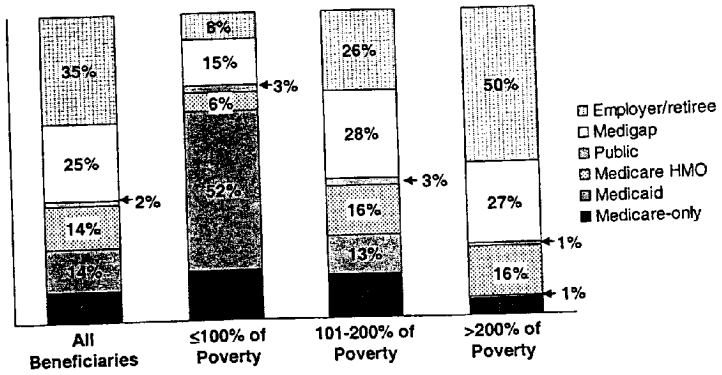


Total = 6.2 million Medicare HMO enrollees, 2000

SOURCE: Cassidy, A., and M. Gold. "Medicare + Choice in 2000: Will Enrollees Spend More and Receive Less? Report prepared for the Commonwealth Fund; HCFA 2000.

Exhibit 8

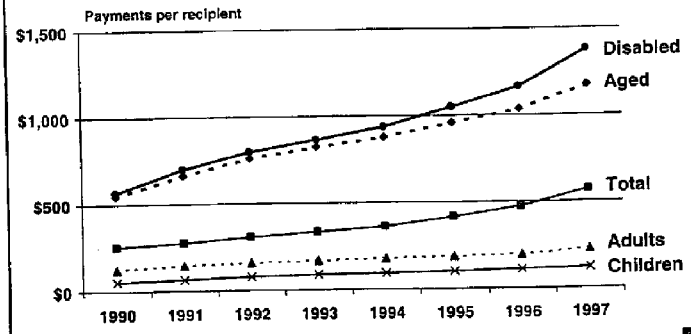
Supplemental insurance for Medicare beneficiaries varies by income



Note: Columns may not sum to 100%; other sources of public coverage not shown.
SOURCE: Urban Institute analysis of 1997 Medicare Current Beneficiary Survey.

Exhibit 9

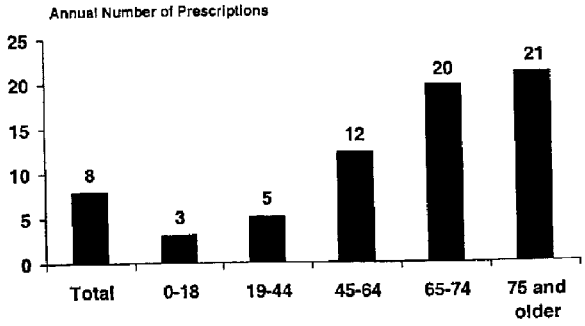
Medicaid prescription drug payments for the aged and disabled are higher and rising more rapidly



SOURCE: Baugh, et al. Trends in Medicaid Drug Utilization and Payments, 1990-97 *HCFA Review*, Spring 1999.

Exhibit 10

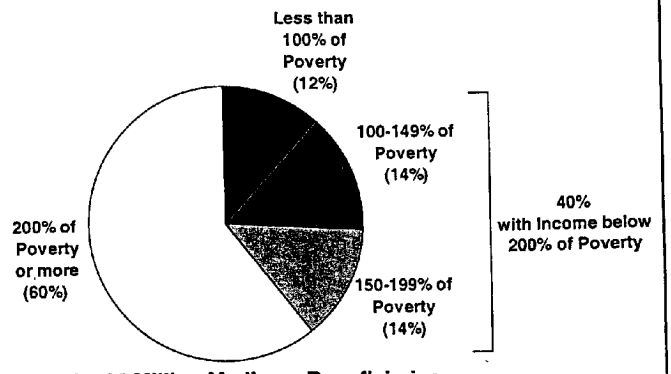
Prescription drug utilization increases with age



SOURCE: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996.

Exhibit 11

Four in ten Medicare beneficiaries have incomes below 200% of poverty

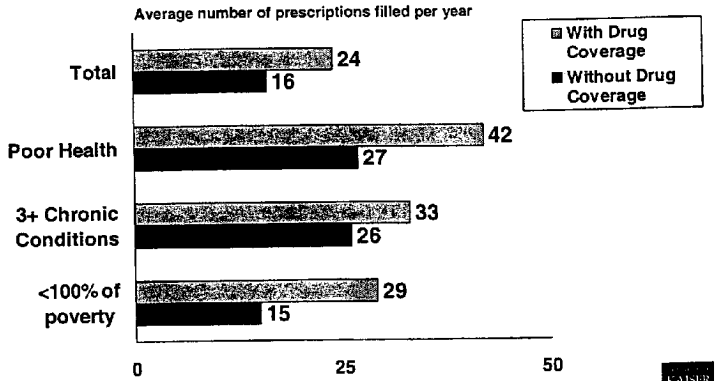


Total = 36 Million Medicare Beneficiaries

Note: Reflects income from all household family members. If income from household family members other than spouse were excluded, 17% would have incomes below poverty. 1999 federal poverty was $8,240 for individuals; $11,060 for couples.
SOURCE: Urban Institute estimates based on 2000 Current Population Survey.

Exhibit 12

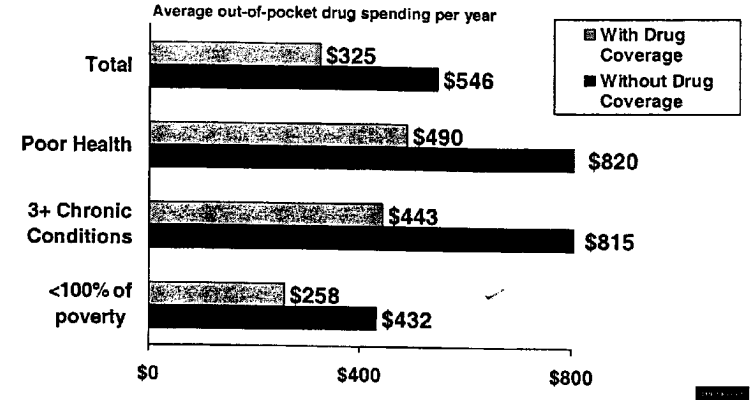
Medicare beneficiaries *without* drug coverage fill fewer prescriptions



Note: ADL = Activity of Daily Living
SOURCE: Poisal, J.A. and L. Murray, *Health Affairs*, March/April 2001.

Exhibit 13

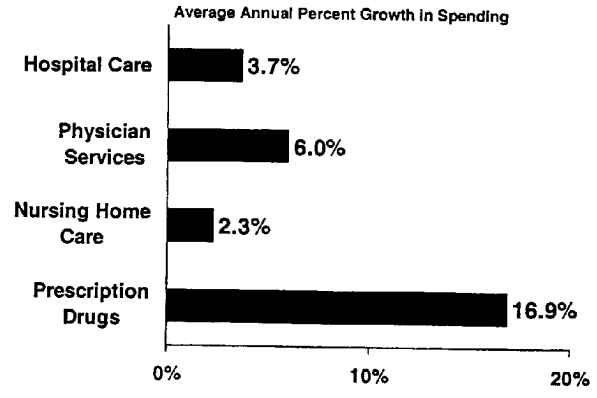
Medicare beneficiaries *without* drug coverage face higher out-of-pocket drug costs



Note: ADL = Activity of Daily Living
SOURCE: Poisal, J.A., and L. Murray, *Health Affairs*, March/April 2001.

Exhibit 14

Spending grew more rapidly for prescription drugs than for other services in 1999



SOURCE: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group.

RESPONSE TO A QUESTION FROM SENATOR ROCKEFELLER

Question: Rural beneficiaries use nearly 10 percent more prescriptions, pay 25 percent more out-of-pocket for drugs than urban beneficiaries and are 50 percent less likely to have any prescription drug coverage. In the state of West Virginia, 59 percent of the population is classified as rural. I believe that the market has clearly failed with regards to the provision of prescription drugs to the rural population. I believe that the only way to ensure access to prescription drugs for rural beneficiaries is to create a national benefit administered through the Medicare program. Can you talk a little about the importance of a reliable prescription drug option for rural beneficiaries?

Answer: Medicare beneficiaries who live in rural parts of the country are disproportionately likely be without prescription drug coverage. In 1998, the most recent year for which data are available, 37% of rural beneficiaries lacked coverage for the costs of prescription medications, as opposed to 27% of the Medicare population as a whole. These beneficiaries are particularly vulnerable to access problems given the nature of many rural delivery systems.

For these reasons, it is critical that proposals to add a drug benefit to Medicare—as well as broader structural reforms—take into account both the greater needs of the rural Medicare population and the diminished delivery-system capacities of the areas in which they live. Current proposals for the design of a prescription drug benefit vary widely with respect to their approaches to the challenge of guaranteeing access for beneficiaries living in rural and other difficult-to-serve areas.

Many proposals would rely on private, risk-bearing entities such as HMOs or other Medicare+Choice plans to deliver a new Medicare drug benefit. While private plans such as HMOs have entered some rural areas, it is unclear whether such plans would choose to serve and stay in all rural areas to offer a reliable and stable source of drug coverage to the Medicare population. Only 14% of rural Medicare beneficiaries have a managed-care plan available in their area today. Further, the recent withdrawals of private plans have occurred disproportionately in rural parts of the country. In sum, even taking into consideration the newly established floor on plan payments, the entry and stability of private plans in rural markets cannot be assured given the uncertainty surrounding how plans would be paid and the level of risk they would be asked to bear.

RESPONSES TO QUESTIONS FROM SENATOR HATCH

Question: Ms. Neuman, in your testimony, you state that according to data released just last week that more than 10 million Medicare beneficiaries lacked prescription drug coverage through 1988. You also state that this number masks the much larger share of beneficiaries, approximately one-half, who didn't have continuous coverage throughout the year.

My first question is who released the data you cited in your testimony?

Answer: The data I included in my testimony concerning the number of Medicare beneficiaries with and without drug coverage are from a recent article by John Poisal and Lauren Murray in the current issue of the journal, *Health Affairs*. The authors base their findings on data from the 1998 Medicare Current Beneficiaries Survey (MCBS). As you mention in your question, I also referred to the observation that, while more than a quarter of the Medicare population lacked drug throughout the year in 1998, many more lacked coverage for some portion of the year. This research on patterns of prescription drug coverage within the Medicare population was conducted by Bruce Stuart and colleagues and is featured in the same issue of *Health Affairs*. The authors' more-detailed findings are based on earlier data from the MCBS, covering 1995 and 1996.

Question: I have also noted your support for a uniform drug benefit instead of an actuarially defined benefit. One of the biggest problems we have faced with the Medicare program is that defined benefits in the program are limiting and it is often difficult to add new Medicare benefits. Just look at how long it took Congress to include preventative health benefits for Medicare.

How would a defined benefit package help seniors? What guarantees would be put in place to ensure seniors that they would have access and choice to medications? And who would determine which drugs are covered and which are not covered.

I believe that one of the most serious problems with the Medicare program is that Congress is responsible for expanding benefits. Most of us in the Congress are not medical experts, and therefore, in my opinion, we should not be responsible for making important coverage decisions.

Answer: The question of whether a new Medicare drug benefit should be a uniform and defined benefit versus one of some actuarially determined value is central to many of the proposals now under consideration. As with many of the key design

questions being debated today, both approaches have their strengths and weaknesses.

A uniform benefit would guarantee all beneficiaries the same benefit design in terms of premiums, deductibles, cost-sharing requirements, and catastrophic protections regardless of beneficiaries' health status or area of residence. This approach would mirror that of Medicare Parts A and B with respect to using agreed-upon levels of cost-sharing to be required of beneficiaries. A uniform benefit would have the advantages of making coverage clear and easy to understand for beneficiaries, of granting all beneficiaries an equal benefit regardless of whether they opted for coverage through traditional Medicare or a managed-care plan, and of avoiding the adverse selection problems likely to arise when multiple benefit packages are offered.

An alternative approach would be to permit plans to vary the benefit designs they offer, provided they have the same actuarial value. Some prefer this approach to the defined benefit option because it would avoid a "one size fits all" approach, giving plans greater flexibility to adapt benefits to rapidly changing drug technologies, as well as new developments in delivery systems more broadly. This approach would also relieve the government of decisions regarding benefit design and could limit the government's liability by capping the dollar value of the benefit package.

There are, however, some concerns with this approach. The variation of drug benefits offered across both plans and communities could create potential fairness concerns as well as considerable confusion for beneficiaries required to choose among them. Variations in benefit design would also raise the potential for adverse selection, which arises when benefits are tailored to attract healthier and lower-cost beneficiaries. In addition, the dollar cap on per-beneficiary drug benefits raises the potential for shifting costs to beneficiaries over time, should the actuarial value of the benefit fail to keep pace with the rise in drug spending.

On its own, the question of whether to offer a uniform benefit or a benefit of some actuarially determined value does not speak to the way in which decisions would be made about covering specific medications under a new drug benefit. Many proposals, including those that offer a defined benefit through traditional Medicare, would delegate these difficult coverage decisions to private plans (such as pharmacy benefit managers or HMOs). Others would establish an independent, government committee to set coverage guidelines for plans.

PREPARED STATEMENT OF RAY SCHEPPACH

Mr. Chairman and members of the committee, I appreciate the opportunity to appear before you today on behalf of the nation's Governors.

PRESCRIPTION DRUG COVERAGE FOR SENIORS

One of the most critical responsibilities we have is to protect and improve the health of our nation's citizens. To this end, the Medicare and Medicaid programs have been tremendously successful. Seniors are more likely to have health insurance coverage than any other group, and, together with Social Security, Medicare and Medicaid have drastically reduced the number of seniors living in poverty. In addition, they have given American families the assurance that they will not have to bear by themselves the burden of illness of their elderly or disabled parents or other family members.

Despite Medicare's success, the program faces enormous challenges. The benefits package simply does not meet the health care needs of seniors today. There is no comprehensive long-term care benefit, no real focus on preventive health and wellness, and as we will discuss today, no comprehensive outpatient drug benefit either. For the 5.4 million seniors fully eligible for both Medicaid and Medicare (dual eligibles), Medicaid provides coverage for all of their pharmaceutical needs. Other seniors receive drug coverage through Medicare+Choice plans, Medigap, employer-sponsored retiree coverage, state-funded assistance programs, or through costly out-of-pocket expenditures.

Any consideration of adding a prescription drug benefit to the Medicare program must recognize that states have shouldered much of these costs for years through Medicaid and state assistance programs, while these costs should have been borne by the federal Medicare program. If a drug benefit is added to Medicare, it should be administered through the Medicare program, not merely delegated to the states to administer on behalf of the federal government.

States have gained valuable lessons in providing drug benefits for Medicaid beneficiaries and would share best practices with the Health Care Financing Administration (HCFA) in making coverage decisions, negotiating rates, and contracting with pharmacy benefits managers.

For low-income Medicare beneficiaries, Medicaid fills the gaps in Medicare coverage by providing assistance for Medicare premiums and cost-sharing expenses and by covering the costs of outpatient prescription drugs and long-term care. Medicaid serves not only low-income Medicare beneficiaries but also higher income Medicare beneficiaries as well, who turn to Medicaid after exhausting their own resources to pay for their care.

Moreover, because Medicaid's role in providing coverage for these individuals is supplementary to Medicare, states are in an untenable position. States share the responsibility for providing coverage but lack any way to affect the policies that govern Medicare or to manage the up-front primary and acute care treatment decisions that drive beneficiaries' use of long-term care services and Medicaid spending. Governors ask that you remember the interrelation of the two programs and consider the potential implications for Medicaid before proposing changes to Medicare.

Since 1988, the federal government has increasingly passed on to the states the responsibility to cover the cost-sharing burdens of many low-income Medicare beneficiaries {e.g., the Qualified Medicare Beneficiary (QMB) Program, the Specified Low-Income Medicare Beneficiary (SLMB) Program, and the new groups of beneficiaries created by the Balanced Budget Act of 1997 (BBA)—the Qualifying Individuals (QI)}. The nation's Governors want to ensure that elderly beneficiaries receive the best possible care and are committed to providing the highest quality of services to seniors who are eligible for Medicaid benefits. But for the QMBs and SLMBs and other groups, Congress should recognize that the strength and responsibility of the Medicaid program is in providing high quality services, not in cutting checks. The Governors would therefore recommend that the patchwork of eligibility categories that provide only cost-sharing assistance be streamlined, simplified, and fully federalized.

MEDICAID

Enacted at the same time as Medicare in 1965, and authorized under Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program financed by state and federal governments and administered by the states. There are variations in income eligibility thresholds and coverage among the states, depending on what criteria each state establishes. Within broad national guidelines established by the federal government, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for such services; and administers its own program.

Since its enactment, Medicaid has changed and expansions require coverage for many groups, including the elderly up to 120 percent of poverty. It now covers more Americans than Medicare or any health insurer. It funds care for 1 in 8 Americans, 1 in 4 children, 40 percent of the births in the entire country, and approximately one-half of nursing home care. In 1990, Medicaid covered 28.9 million people. Due in large part to many state expansions, more than 41 million Americans received services through Medicaid in 1999 at a total cost exceeding $200 billion.

Medicaid expenditures for prescription drugs almost doubled in the years between 1993 and 1998, rising from $8 billion to almost $14 billion, despite a marked decrease in the total number of beneficiaries utilizing prescription drugs (from 24 million to 19 million) over the same period. Over that period, the average drug expenditures per beneficiary increased from $333 to $699 per year. Prescription drug expenditures, at approximately 10 percent, represent the third largest component of the Medicaid budget, behind hospitals and nursing homes, and expenditures are increasing at approximately 18 percent per year.

MEDICAID DRUG REBATE PROGRAM

Under current Medicaid law, coverage of prescription drugs is an optional service. All states have elected to cover prescription drugs and in order to do so, must abide by the rules of the rebate program. Basically, the program provides an incentive for states by requiring the drug companies to offer discounts to the states on prescription drugs. In return, states are essentially obligated to cover all prescription drugs developed by the major drug companies and approved by the Food and Drug Administration (FDA).

Because Medicaid is an "all-or-nothing" program, every individual on the program is entitled to receive the drug benefit. Medicaid will reimburse for essentially any pharmaceutical prescribed by a physician with little or no cost-sharing requirement on the part of the beneficiary. There is a brief list of prescription drugs that states are not required to cover (hair growth, smoking cessation, weight loss/gain, fertility, etc.), and some states have implemented limits on the number of prescriptions per month that are available.

There are increasing concerns from some state Medicaid agencies that the Drug Rebate Program no longer adequately meets the needs of state Medicaid programs. Considering the rapid growth already happening in prescription drug costs and the changes that will happen in the health care system as the baby boom generation ages, it is clear that some changes in the program will help states better manage the pharmaceutical benefit. One of the biggest concerns is that in the more than ten years since the enactment of the Drug Rebate Program into law, final regulations on the program have never been promulgated. The absence of effective, enforceable final regulations creates uncertainty for federal and state policymakers in assessing how well the program works, how best to resolve disputes over prices and rebates, and the full range of cost-control options available under the law.

DUAL ELIGIBLES

Although states play a key role in funding the services provided to many low-income seniors, the most evident connection between Medicare and states is for individuals eligible for both Medicare and Medicaid coverage. Approximately 15 percent of Medicare beneficiaries also are eligible for Medicaid. These dually eligible beneficiaries, however, account for 30 percent of all Medicare spending, or about $62 billion in fiscal 1997.

Dually eligible beneficiaries also are an expensive population for Medicaid programs. Although they account for only 16 percent of Medicaid recipients, dual eligibles account for 35 percent of Medicaid expenditures, or about $58 billion in fiscal 1997.

Dually eligible beneficiaries are a particularly vulnerable and high-cost group. Compared with other Medicare beneficiaries, dual eligibles are more likely to suffer from chronic illness and require significant long-term care and social support services. They also are more likely to live alone or in a nursing facility and are less likely to have a living spouse. Of course, dually eligible beneficiaries are much poorer, on average, than other Medicare beneficiaries, with 80 percent of dual eligibles having annual incomes of less than $10,000.

Dually eligible beneficiaries also are different from other Medicare beneficiaries in another, very important way: they do not have the same financial incentive to choose among fee-for-service and managed care options, based on differences in price and benefits, because Medicaid programs cover their out-of-pocket costs and provide comprehensive coverage. National data show that dual eligibles are 75 percent less likely than other Medicare beneficiaries to enroll in managed care plans.

The majority of the 6 million dually eligible beneficiaries, about 5.4 million, receive full Medicaid coverage. Medicaid provides coverage for their Medicare premium and cost-sharing expenses and for services not covered by Medicare, including long-term care and outpatient prescription drugs.

The remaining 600,000 beneficiaries are not eligible for full Medicaid coverage but do receive Medicaid assistance for Medicare premiums and/or cost-sharing expenses. They include individuals with incomes up to 120 percent of the federal poverty level (i.e. QMBs and SLMBs) and, at least through 2002, individuals with incomes between 120 percent and 175 percent of the poverty level (QIs).

Not included in these population figures are low-income Medicare beneficiaries who are eligible for Medicaid coverage but who decide to forgo such assistance or who are not aware that assistance is available. States have been criticized for failing to enroll 100 percent of eligible seniors in these programs. Although states take their responsibilities seriously and are working with HCFA to identify effective outreach methods, in many cases, the cost of outreach exceeds the value of the benefit to the individual. It simply is not worth the effort for many seniors to apply for federal assistance to receive as little as $1.07 per month.

Allowing the Social Security Administration or some other federal agency to provide assistance to these beneficiaries would streamline a cumbersome system and ensure greater program participation. This common-sense solution would help reverse the trend of creating a patchwork of optional and mandatory eligibility categories that is confusing to both caseworkers and beneficiaries. It would also recognize that the strength of the Medicaid program is in providing vital health care services to low-income beneficiaries, not in cutting checks for a few dollars each month.

LESSONS

In order for a Medicare prescription drug benefit to maximize its potential, there are a number of key lessons to be learned.

- If a universal benefit is created within the Medicare program, it must be a truly federal benefit. Although states have picked up an increasing share of the bur-

den through Medicaid and state-only programs, these are "band-aids" and should not be viewed as an alternative to a comprehensive Medicare benefit. States have borne the costs of the federal responsibility in this area for many years and should not be penalized by maintenance of effort provisions, either in Medicaid or in the state-funded assistance programs.

- To the extent that full or partial subsidies for the low-income are created or enhanced, it is critical that they be federally financed. Otherwise, any benefit that relies on recipient cost sharing will simply be a cost-shift to the Medicaid program, which finances all forms of cost sharing for dual eligibles. To the extent to which states are required to administer a subsidy program, 100 percent federal financing should be provided not only for the cost of the benefit, but also for the cost of its administration.
- There must be the ability for the federal government to negotiate on the basis of price (or to be able to contract with entities that can). Although imposing price controls is an extreme measure that would be controversial, there must be recognition that the volume of drugs purchased under Medicare should drive the market price down to an affordable level.
- The key to an effective pharmaceutical benefit is management. Whether this is disease-specific management for conditions like diabetes or general case management for seniors who take multiple prescriptions, this tool clearly improves health outcomes and reduces waste and misuse.
- Aggressive utilization review is extremely important in reducing inappropriate prescribing. Reviews on the front end, such as prior authorization or on the back end, such as a comprehensive drug utilization review board, are vital to ensuring that physicians are prescribing and seniors are receiving the most appropriate medications.
- Almost unheard of in 1965, prescription drugs are now as important to seniors' health as hospital coverage and physician services. With the increasing importance of both pharmaceuticals and the pharmaceutical industry, any decisions about coverage and costs will be highly visible and highly politicized.
- It is critical for Medicare to utilize an effective information system. With the right hardware and software in place, pharmacists can have enough information at their fingertips to know which doctors are prescribing which drugs for each patient; to be able to do real-time prior authorization; and to be able to prevent contraindications from drug interactions. A well-trained, well-equipped pharmacist is critically important to the smooth operation of a drug benefit.
- Because there is likely to be too little money in the system to provide all drugs for all beneficiaries, and there are legitimate concerns about subsidizing certain types of drugs, some choices will need to be made about coverage. The Medicaid program allows states to deny coverage for certain drugs, such as those used for hair growth, weight loss/gain, fertility, and smoking cessation. This list is appropriate as a model for Medicare but should also contain provisions for dealing with so-called "lifestyle drugs." With limited budgets, government programs should be focused on providing medically necessary treatments. Therefore additional provisions need to be incorporated to allow the program to target resources on necessary treatments.
- If a voluntary benefit is created within the Medicare program, there must be a mechanism to allow states to require enrollment for individuals dually eligible for Medicare and Medicaid. Dual eligibles currently have 100 percent of their out-of-pocket costs paid for by the Medicaid program, and there is no incentive for them to enroll in a voluntary drug benefit. This is also true for any aspect of the program that relies on fiscal incentives or market decisions to influence beneficiary behavior.

I thank you again for the opportunity to be a part of this hearing. I look forward to answering any questions you may have.

PREPARED STATEMENT OF DAVID M. WALKER

Chairman Grassley, Ranking Member Baucus, and Members of the Committee:

I am pleased to be here today as you consider the need to strengthen and modernize the Medicare program. In previous testimony before this Committee, I have consistently stressed that without meaningful reform, demographic and cost trends will drive Medicare spending to unsustainable levels but that today's projected surpluses provide an opportunity to act before these trends make needed changes more painful and disruptive.

Although Medicare's short-term outlook has improved since I last testified, this should not distract us from focusing on the more important long-term perspective.

The Medicare Trustees' latest projections incorporate more realistic assumptions about long-term health care spending and, as a result, the long-term outlook for Medicare's financial future has deteriorated substantially since the last Trustees' Annual Report. The Medicare Trustees and the Congressional Budget Office (CBO) now agree that spending will grow faster than was previously predicted. At the same time, the fiscal discipline imposed through the Balanced Budget Act of 1997 (BBA) continues to be challenged, while interest in modernizing the Medicare benefits package to include prescription drug coverage has increased. As a result, the need for meaningful Medicare reform is even clearer today.

We must capitalize on momentum gathering in this Committee and elsewhere to take action to adopt effective cost containment reforms alongside potential benefit expansions. It is important that any benefit expansion efforts be coupled with adequate program reforms so as not to worsen Medicare's long-range financial condition. Ultimately, any comprehensive Medicare reform must confront several fundamental challenges. In summary:

- Our long-term budget simulations show that demographics and health care spending will drive projected long-term deficits and debt. Our January 2001 long-term simulations show that even if all unified surpluses are saved—which no one expects will occur—large and persistent deficits will return in the long term absent policy change.
- Medicare spending is likely to grow faster than previously estimated. The Medicare Trustees are now projecting that, in the long-term, Medicare costs will eventually grow at 1 percentage point above per-capita gross domestic product (GDP) each year—about 1 percentage point faster than the previous assumption. Accordingly, as estimated by the Office of the Actuary at the Health Care Financing Administration, (HCFA), the estimated net present value of future additional resources needed to fund Part A Hospital Insurance (HI) benefits over the next 75 years increased from $2.6 trillion last year to $4.6 trillion—an increase of more than 75 percent.
- Measurement of Medicare's sustainability can no longer be merely the traditional measure of HI Trust Fund solvency that has been used to assess the program's financial status. Both Part A expenditures financed through its Trust Fund and Part B Supplementary Medical Insurance (SMI) expenditures financed through general revenues and beneficiary premiums must be taken into consideration.
- Since the cost of a drug benefit will boost these spending projections even further, adding drug coverage under Medicare's already dark financial cloud will require difficult policy choices that will likely have a significant effect on beneficiaries, the program, and the marketplace.
- Properly structured reforms to promote competition among health plans can help make beneficiaries more cost conscious. However, improvements to traditional fee-for-service (FFS) Medicare are also critical, as it will likely remain dominant for some time to come.
- Fiscal discipline is difficult, but the continued importance of traditional Medicare underscores the need to base adjustments to provider payments on hard evidence rather than anecdotal information and to carefully target relief where it is both needed and deserved.
- Reform of Medicare's management, which is on the table as discussions of Medicare program reforms proceed, similarly will require carefully targeted efforts to ensure that adequate resources are appropriately coupled with increased accountability.
- Ultimately, we will need to look at broader health care reforms to balance health care spending with other societal priorities. In doing this, it is important to look at the entire range of federal policy tools—tax policy, spending, and regulation. It is also important to note the fundamental differences between health care wants, which are virtually unlimited, from needs, which should be defined and addressed, and overall affordability, of which there is a limit.

The new consensus that Medicare is likely to cost more than previously estimated serves to reinforce the need to take prompt action. Realistically, reforms to address the Medicare program's huge long-range financial balance will need to proceed incrementally. In addition, efforts to update the program's benefits package will need careful and cautious deliberation. This is especially important in connection with a potential prescription drug benefit, as this coverage represents one of the fastest-growing expenditures for public and private health plans. Therefore, the time to begin these difficult, but necessary, incremental steps is now.

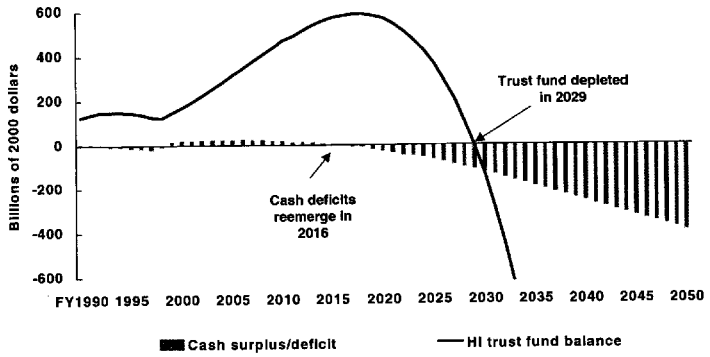
MEDICARE'S LONG-TERM OUTLOOK HAS WORSENED

As I have previously testified before this Committee, Medicare as currently structured is fiscally unsustainable. While many people have focused on the improvement in the HI Trust Fund's shorter-range solvency status, the real news is that Medicare's long-term outlook has worsened significantly during the past year. A new consensus has emerged that previous program spending projections have been based on overly optimistic assumptions and that actual spending will grow faster than has been assumed.

TRADITIONAL HI TRUST FUND SOLVENCY MEASURE IS A POOR INDICATOR OF MEDICARE'S FISCAL HEALTH

First, let me talk about how we measure Medicare's fiscal health. In the past, Medicare's financial status has generally been gauged by the projected solvency of the HI Trust Fund, which covers primarily inpatient hospital care and is financed by payroll taxes. Looked at this way—and based on the latest Trustee's report—Medicare is viewed as solvent through 2029. (See fig. 1).

Figure 1: Medicare's Hospital Insurance Trust Fund Faces Cash Deficits as Baby Boomers Retire



Note: Projections are based on the intermediate assumptions of the 2001 HI Trustees' Report.

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

However, HI trust fund solvency does not measure the growing cost of the Part B Supplementary Medical Insurance (SMI) component of Medicare, which covers outpatient services and is financed through general revenues and beneficiary premiums. Part B accounts for somewhat more than 40 percent of Medicare spending and is expected to account for a growing share of total program dollars.

In addition, HI trust fund solvency does not mean the program is financially healthy. Although the trust fund is expected to remain solvent until 2029, HI outlays are predicted to exceed HI revenues beginning in 2016. As the baby boom generation retires and the Medicare-eligible population swells, the imbalance between outlays and revenues will increase dramatically. Thus, in 15 years the HI trust fund will begin to experience a growing annual cash deficit. At that point, the HI program must redeem Treasury securities acquired during years of cash surplus. Treasury, in turn, must obtain cash for those redeemed securities either through increased taxes, spending cuts, increased borrowing, retiring less debt, or some combination thereof.

Clearly, it is total program spending—both Part A and Part B—relative to the entire federal budget and national economy that matters. This total spending approach is a much more realistic way of looking at the combined Medicare program's sustainability. In contrast, the historical measure of HI trust fund solvency cannot tell us whether the program is sustainable over the long haul. Worse, it can serve to distort the timing, scope, and magnitude of our Medicare challenge.

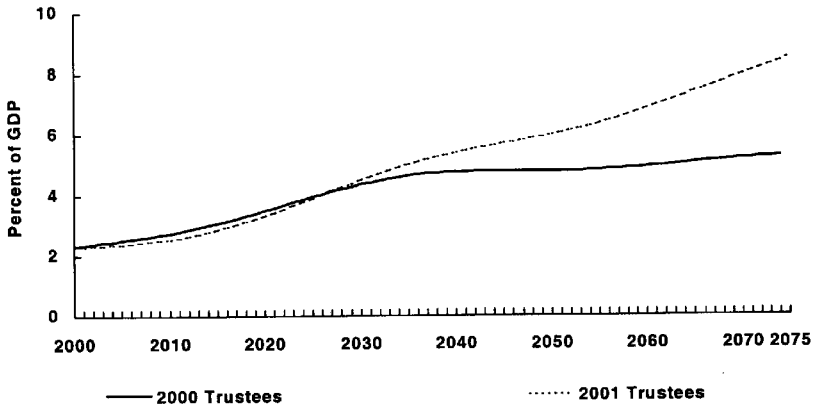
New Estimates Increase Urgency of Reform Efforts

Besides looking at total program spending, any assessment of Medicare's financial condition must acknowledge that absent meaningful program reforms, program cost

growth will likely be greater than has been previously projected. A technical panel advising the Medicare Trustees recently recommended assuming that future per-beneficiary costs for both HI and SMI eventually will grow at a rate 1 percentage point above GDP growth—about 1 percentage point higher than had previously been assumed.[1] That recommendation was consistent with a similar change CBO made to its Medicare and Medicaid long-term cost growth assumptions last year.[2] In their new estimates published on March 19, 2001, the Trustees adopted the technical panel's long-term cost growth recommendation.[3] The Trustees note in their report that this new assumption substantially raises the long-term cost estimates for both HI and SMI. In their view, incorporating the technical panel's recommendation yields program spending estimates that represent a more realistic assessment of likely long-term program cost growth. (See fig. 2.)

Under the old assumption (the Trustees' 2000 best estimate intermediate assumptions), total Medicare spending consumes 5 percent of GDP by 2063. Under the new assumption (the Trustees' 2001 best estimate intermediate assumptions), this occurs almost 30 years sooner—2035—and by 2075 Medicare consumes over 8 percent of GDP, compared with 5.3 percent under the old assumption. The difference clearly demonstrates the dramatic implications of a 1 percentage point increase in annual Medicare spending over time.

Figure 2: Medicare Spending as a Share of GDP Under Old and New Assumptions



Note: Data are gross outlays as projected under the Trustees' intermediate assumptions.

Source: GAO analysis of data from the 2000 and 2001 HI and SMI Trustees Reports.

Figure 3 reinforces the need to look beyond the HI program. HI is only the first layer in this figure. The middle layer adds the SMI program, which is expected to grow faster than HI in the near future. By the end of the 75-year projection period, SMI will represent almost half of total estimated Medicare costs.

If federal Medicaid spending is also considered, an even more complete picture of the future health care entitlement burden emerges. Including Medicaid, federal health care costs will grow to 14.5 percent of GDP from today's 3.5 percent. Taken together, the two major government health programs—Medicare and Medicaid—represent an unsustainable burden on future generations. In addition, this figure re-

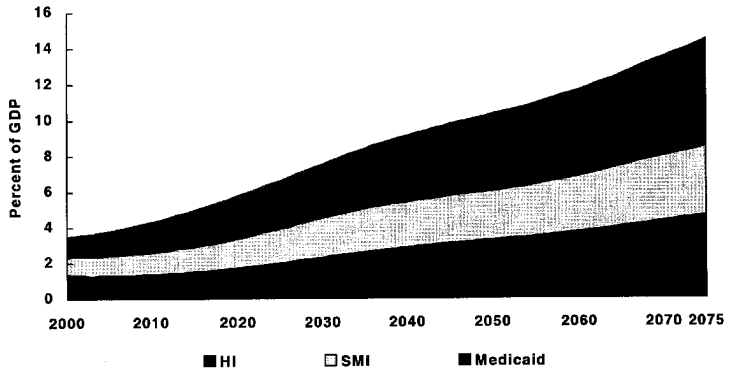
[1] Technical Review Panel on the Medicare Trustees Report, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* (Dec. 2000). As the panel noted, for many years the Medicare projections have been based on an assumption that in the long run, average per-beneficiary costs would increase at about the same rate as program underlying funding sources. For HI, this meant that expenditures were assumed to increase at the same rate as average hourly earnings. For SMI, this meant that per-beneficiary costs were assumed to grow at the same rate as per-capita GDP.

[2] CBO, *The Long-Term Budget Outlook* (Oct. 2000).

[3] See *2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (March 2001) and *2001 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (March 2001).

flects only the federal government's share—the burden of states' Medicaid matching costs on state budgets is another fiscal challenge. According to a recent National Governors Association statement, increased Medicaid spending has already made it difficult, if not impossible, for states to increase funding for other priorities.

Figure 3: Medicare and Medicaid Spending as a Share of GDP



Notes:
1. Medicare data are gross outlays as projected under the Trustees' 2001 intermediate assumptions.
2. Federal Medicaid data based on CBO's October 2000 long-term budget outlook.

Source: GAO analysis of data from the Congressional Budget Office and the March 2001 HI and SMI Trustees Reports.

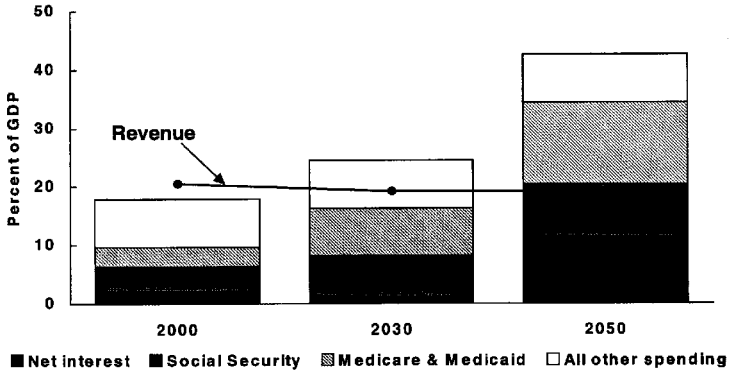
When viewed from the perspective of the federal budget and the economy, the growth in health care spending will become increasingly unsustainable over the longer term.[4] Our message remains the same as in my earlier appearances before this Committee: to move into the future with no changes in federal health and retirement programs is to envision a very different role for the federal government in the future. Assuming, for example, that Congress and the President adhere to the often-stated goal of saving the Social Security surpluses, our long-term simulations show a world by 2030 in which Social Security, Medicare, and Medicaid absorb most of the available revenues within the federal budget.

Under this scenario, these programs would require more than three-quarters of total federal revenue even without adding a prescription drug benefit.[5] (See fig. 4.)

[4] See *Long-Term Budget Issues: Moving from Balancing the Budget to Balancing Fiscal Risk* (GAO–01–385T, Feb. 6, 2001). Given CBO's October 2000 long-term health cost estimates and the Medicare technical panel's higher long-term cost growth recommendation, we incorporated higher long-term health care cost growth consistent with the Medicare technical panel's recommendation into our January 2001 updates of our long-term simulations.

[5] The "Save the Social Security Surplus" simulation assumes that tax cuts and/or spending increases equal to the size of the on-budget surplus are enacted.

Figure 4: Composition of Federal Spending as a Share of GDP Under the "Save the Social Security Surpluses" Simulation

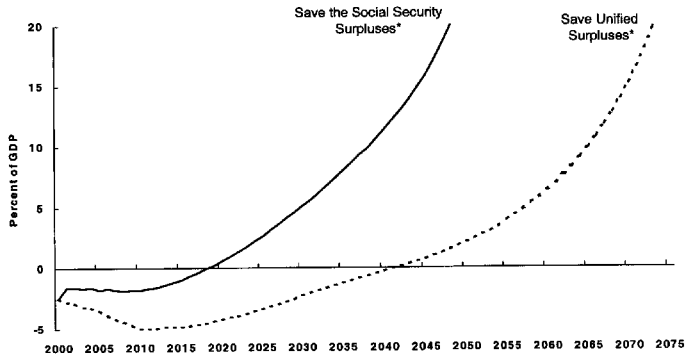


Notes:
1. Revenue as a share of GDP declines from its 2000 level of 20.6 percent to 19.3 percent due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.
2. The Save the Social Security Surpluses simulation can be run only through 2055 due to the elimination of the nation's capital stock.

Source: GAO's January 2001 analysis.

Little room would be left for other federal spending priorities such as national defense, education, and law enforcement. Absent charges in the structure of Medicare and Social Security, sometime during the 2040s government would do nothing but mail checks to the elderly and their health care providers. Accordingly, substantive reform of the Medicare and Social Security programs remains critical to recapturing our future fiscal flexibility. As our long-term budget simulations show, this is true even if the entire projected surplus is saved. (See fig. 5.)

Figure 5: Unified Deficits as a Share of GDP Under Alternative Policy Simulations



*Data end when deficits reach 20 percent of GDP.

Source: GAO's January 2001 analysis.

Higher cost estimates are not the only reason why early action to address the daunting challenges of Medicare is critical. First, ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. The high projected growth of Medicare in the coming years means that the earlier reform begins, the greater the savings will be as a result of the effects of compounding.

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our nation's future capacity to afford paying benefits in the face of an aging society. Decisions on how we use today's surpluses can have wide-ranging impacts on our ability to afford tomorrow's commitments. As I have testified before, you can think of the budget choices you face as a portfolio of fiscal options balancing today's unmet needs with tomorrow's fiscal challenges. At the one end—with the lowest risk to the long-range fiscal position—is reducing publicly held debt. At the other end—offering the greatest risk—is increasing entitlement spending without fundamental program reform.

Reducing publicly held debt helps lift future fiscal burdens by freeing up budgetary resources encumbered for interest payments, which currently represent more than 12 cents of every federal dollar spent, and by enhancing the pool of economic resources available for private investment and long-term economic growth. This is particularly crucial in view of the known fiscal pressures that will begin bearing down on future budgets in about 10 years as the baby boomers start to retire. However, as noted above, debt reduction is not enough. Our long-term simulations illustrate that, absent entitlement reform, even saving all projected unified surpluses will ultimately be insufficient to prevent the return of large persistent deficits.

BENEFIT EXPANSIONS WILL NEED TO BE ACCOMPANIED BY MEANINGFUL REFORM

Despite common agreement that, without reform, future program costs will consume growing shares of the federal budget, there is also a mounting consensus that Medicare's benefit package should be expanded to cover prescription drugs, which will add billions to the program's cost. Thus, to contain spending while revamping benefits, the Congress is considering proposals to fundamentally reform Medicare. Our work on the nuts and bolts of the Medicare program provides, I believe, some considerations that are relevant to your discussion regarding the potential addition of a prescription drug benefit, various Medicare reform options based on competition, effective implementation and refinement of new policies, and improving program management. I make these observations ever mindful of the need to ensure the program's sustainability for the longer term.

Adding a Fiscally Responsible Prescription Drug Benefit Will Entail Multiple Trade-Offs

Among the major policy challenges facing the Congress today is how to reconcile Medicare's unsustainable long-range financial condition with the growing demand for an expensive new benefit—namely, coverage for prescription drugs. It is a given that prescription drugs play a far greater role in health care now than when Medicare was created. Today, Medicare beneficiaries tend to need and use more drugs than other Americans. However, because adding a benefit of such potential magnitude could further erode the program's already unstable financial condition, we face difficult choices about design and implementation options that will have a significant impact on beneficiaries, the program, and the marketplace.

Let's examine the current status regarding Medicare beneficiaries and drug coverage. About a third of Medicare beneficiaries have no coverage for prescription drugs. Some beneficiaries with the lowest incomes receive coverage through Medicaid. Some beneficiaries receive drug coverage through former employers, some can join Medicare+Choice plans that offer drug benefits, and some have supplemental Medigap coverage that pays for drugs. However, significant gaps remain. For example, Medicare+Choice plans offering drug benefits are not available everywhere and generally do not provide catastrophic coverage. Medigap plans are expensive and have caps that significantly constrain the protection they offer. Thus, beneficiaries with modest incomes and high drug expenditures are most vulnerable to these coverage gaps.

Overall, the nation's spending on prescription drugs has been increasing about twice as fast as spending on other health care services, and it is expected to keep growing. Recent estimates show that national per-person spending for prescription drugs will increase at an average annual rate exceeding 10 percent until at least 2010. As the cost of drug coverage has been increasing, employers and Medicare+Choice plans have been cutting back on drug benefits by raising enrollees' cost-sharing, charging higher copayments for more expensive drugs, or eliminating the benefit altogether.

It is not news that adding a prescription drug benefit to Medicare will be costly. However, the cost consequences of a Medicare drug benefit will depend on choices made about its design—including the benefit's scope and financing mechanism. The details of its implementation will also have a significant impact on beneficiaries, program spending, and the pharmaceutical market. Experience suggests that some combination of enhanced access to discounted prices, targeted subsidies, and measures to make beneficiaries aware of costs may be needed. Any option would need to balance concerns about Medicare substainability with the need to address what will likely be a growing hardship for beneficiaries in obtaining prescription drugs.

Reform Options Based on Competition Offer Advantages but Contain Limitations

As you consider the options to add a drug benefit, fiscal prudence argues for balancing this action with the adoption of meaningful Medicare spending reforms. Before the 107th Congress are two leading proposals, popularly known as Breaux-Frist I and Breaux-Frist II. Both proposals are based on a model in which a competitive process determines the amount that the government and beneficiaries pay to participating health plans. 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. Medicare permits plans to earn a reasonable profit, equal to the amount they can earn from a commercial contract. Efficient plans that keep costs below the fixed payment amount can use the "savings" to enhance their benefit packages, thus attracting additional members and gaining market share. Under this arrangement, competition among Medicare plans may produce advantages for beneficiaries, but the government reaps no savings [6,7]

In contrast, the competitive premium approach of both Breaux-Frist proposals offers certain advantages. Instead of having the government administratively set 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 at least a required minimum Medicare benefit package. Under both proposals, beneficiaries would generally pay a portion of the premium and Medicare would pay the rest. Plans operating at lower cost could reduce premiums, attract beneficiaries, and

[6] Beginning in 2003, plans can use savings to reduce beneficiaries' Part B premiums. Plans choosing to do so must charge a portion of these savings with the program.

[7] In fact, the government has been losing money on the Medicare+Choice program. Medicare pays more, on average, for beneficiaries enrolled in managed care plans than if these individuals had remained in traditional Medicare. See *Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending* (GAO/HEHS–00–161, Aug. 23, 2000).

increase market share. Beneficiaries who joined these plans would enjoy lower out-of-pocket expenses. Unlike today's Medicare+Choice program, the premium support approach provides the potential for taxpayers to benefit from the competitive forces. As beneficiaries migrated to lower-cost plans, the average government payment would fall.

A key difference between the two Breaux-Frist proposals is in how the program's contribution is determined. Under Breaux-Frist I, traditional Medicare would, like the other plans, have to set a premium price. The amount of the program contribution would be based on the average of the traditional plan's premium price and the prices set by the other plans. Under Breaux-Frist II, the program contribution would be based on the traditional plan's premium price alone. Under either version, Medicare costs would be more transparent: beneficiaries could better see what they and the government were paying for in connection with health care expenditures. More importantly, both beneficiaries and the government would share in the savings if plans lower premiums to gain market share.

Experience with the Medicare+Choice program reminds us that competition in Medicare has its limits. First, not all geographic areas are able to support multiple health plans. Medicare health plans historically have had difficulty operating efficiently in rural areas because of a sparseness of both beneficiaries and providers. In 2000, 21 percent of rural beneficiaries had access to a Medicare+Choice plan, compared to 97 percent of urban beneficiaries. Second, separating winners from losers is a basic function of competition. Thus, under a competitive premium approach, not all plans would thrive, requiring that provisions be made to protect beneficiaries enrolled in less successful plans.

Effective Implementation Requires Capacity to Assess and Refine New Policies

The fundamental nature of proposed Medicare reforms, such as adding a drug benefit or reshaping the program's design, makes monitoring the effects of these changes a necessary responsibility. Today, however, major difficulties exist in measuring the effects of Medicare policies in a comprehensive and timely manner, making it difficult to assess the appropriateness of both program expenditures and provision of services.

Although Medicare is the nation's largest third-party payer, some of its vital information systems are decades old and operate on software no longer commonly used. These systems house a wealth of health and payment data but lack the flexibility to generate the kind of prompt and reliable reports that other large payers use to ensure health care quality and efficiency. This death of timely, accurate, and useful information hinders effective policymaking. This shortcoming is particularly significant in a program where small rate changes developed from faulty estimates can mean billions of dollars in overpayments or underpayments.

Our work on BBA payment reforms shows the importance of data-driven analyses in determining the impact of policy changes. Providers affected by BBA-mandated lower rates, lower rate increases, or altogether new payment systems blamed the BBA for their financial difficulties and pressured the Congress to undo some of the act's payment reforms. The Congress responded by making adjustments in subsequent legislation, but the affected providers argue that more changes are needed and call for higher payments on the basis of anecdotal evidence. Medicare analysts were ill-equipped to address these concerns through objective analysis because the necessary program data were not readily available. Our own reviews of BBA provisions and their impact showed that payments generally were adequate to cover providers' Medicare costs and ensure beneficiary access, although we identified areas where refinements would improve the appropriateness of rates to individual providers.

The lesson is that better information, promptly generated, can help policymakers understand the budgetary impact of policy changes and distinguish between desirable and undesirable consequences. Such information could, for example, reveal whether across-the-board rate increases are warranted or will result in overly generous payments for some and inadequate payments for others. Based on good data, refinements can help ensure that payments are not only adequate in the aggregate but also fairly targeted to protect individual beneficiaries and providers. The BBA experience underscores the need to rely on hard data and objective analyses rather than assertions and anecdotes. It also argues for the Congress to ensure that adequate resources are secured for efforts underway to modernize Medicare's information systems and conduct needed research and analyses.

Effective Leadership and Sufficient Capacity Are Critical to Success of Medicare Reform

The extraordinary challenge of developing and implementing Medicare reforms should not be underestimated. Our look at health care spending projections shows that, with respect to Medicare reform, "getting it wrong" will have severe consequences. To get it right, effective program design will need to be coupled with competent program management. With that goal in mind, questions have been raised about the capacity of the Health Care Financing Administration (HCFA)—Medicare's current steward—to administer the Medicare program effectively. Our reviews of Medicare program activities confirm the legitimacy of these concerns and suggest that changes may be necessary to HCFA's focus, structure, resources, and operations.

Several proposals have been made to address HCFA management shortcomings. One approach is to create an entity that would administer Medicare without any non-Medicare responsibilities. The rationale for this view is that HCFA's other responsibilities—administering Medicaid, the State Children's Health Insurance Program, and other oversight, enforcement, and credentialing programs—constitute a separate full-time job. In the meantime, effective Medicare management requires monitoring the claims payment and review activities of more than 50 contractors; setting thousands of payment rates for the various providers of Medicare-covered services; and administering consumer information and beneficiary protection activities for the traditional fee-for-service component and Medicare+Choice plans. Alternative approaches would divide the administration of Medicare's components between HCFA and an entirely new entity. The intention would be to eliminate a conflict of interest that some perceive exists in having the same agency manage both the traditional fee-for-service and the managed care components.

More details would be necessary before the Congress could consider the merits of one approach over another. Creating a new agency allows for a fresh start, eliminating the need to reengineer established practices. The downside is that it typically takes years before a new agency acquires the personnel and infrastructure to become fully effective. In addition, it is questionable whether the perceived advantages of dividing Medicare's administration would outweigh the inefficiencies that could result from duplication or coordination difficulties.

Closely allied with the issue of agency restructuring is the question of agency leadership. Frequent changes in HCFA leadership make it difficult for the agency to develop and implement a consistent long-term vision. The maximum term of a HCFA administrator is, as a practical matter, only as long as that of the President who appointed him or her. Historically, their terms have been much shorter. In the 24 years since HCFA's inception, there have been 20 administrators or acting administrators, whose tenure has been, on average, little more than 1 year. These short tenures have not been conducive to carrying out whatever strategic plans or innovations an individual may have developed for administering Medicare efficiently and effectively. Other federal agencies offer a precedent for an administrator's tenure to span presidential administrations. For example, the FBI director's term is 10 years and the Social Security Administration's term is 6 years. A benefit of similarly lengthening the HCFA administrator's tenure would be to better insulate the program from short-term political pressures.

No matter how well-conceived or how well-led, however, no agency can function effectively without adequate resources and appropriate accountability mechanisms. Over the years, HCFA's administrative dollars have been stretched thinner as the agency's mission has grown. Adequate resources are vital to support the kind of oversight and stewardship activities that Americans have come to count on—inspection of nursing homes and laboratories, certification of Medicare providers, collection and analysis of critical health care data, to name a few. We and other health policy experts, including several former HCFA administrators, contend that too great a mismatch between the agency's administrative capacity and its designated mandate will leave HCFA unprepared to handle Medicare reforms and future population growth. In 1999, Medicare's operating expenses represented less than 2 percent of the program's benefit outlays. Although private insurers incur other costs, such as those for advertising, and seek to earn a profit, they would not attempt to manage such a large and complex program with so comparatively small an administrative budget.

It is not yet clear whether a successfully administered Medicare program requires reengineering HCFA, creating an entirely new agency, or some combination of the two options. What is clear, however, is that the program's effective governance rests on finding a balance between flexibility and accountability—that is, granting an entity adequate flexibility to act prudently and ensuring that the entity can be held accountable for its results-based decisions and their implementation. Moreover, be-

cause Medicare's future will play such a significant role in the future of the American economy, we cannot afford to settle for anything less than a world-class organization to run the program. However, achieving such a goal will require a clear recognition of the fundamental importance of efficient and effective day-to-day operations.

CONCLUSIONS

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. I feel that the greatest risk lies in doing nothing to improve the Medicare program's long-term sustainability. It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Engaging in a comprehensive effort to reform the Medicare program and put it on a sustainable path for the future would help fulfill this generation's stewardship responsibility to succeeding generations. It would also help to preserve some capacity for future generations to make their own choices for what role they want the federal government to play. While not ignoring today's needs and demands, we should remember that surpluses can also serve as an occasion to promote the transition to a more sustainable future for our children and grandchildren.

Updating Medicare's benefit package may be a necessary part of any realistic reform program. Such changes, however, need to be considered in the context of Medicare's long-term fiscal outlook and the need to make changes in ways that will promote the program's longer-term sustainability. We must remember that benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. The BBA experience reminds us about the difficulty of undertaking reform.

Specifically, we must acknowledge that adding prescription drug coverage to the Medicare program would have a substantial impact on program costs. At the same time, many believe it is needed to ensure the financial well-being and health of many of its beneficiaries. The challenge will be in designing and implementing drug coverage that will minimize the financial implications for Medicare while maximizing the positive effect of such coverage on Medicare beneficiaries. Most importantly, any substantial benefit reform should be coupled with other meaningful program reforms that will help to ensure the long-term sustainability of the program. In the end, the Congress should consider adopting a Hippocratic oath for Medicare reform proposals—namely, "Don't make the long-term outlook worse." Ultimately, we will need to engage in a much more fundamental health care reform debate to differentiate wants, which are virtually unlimited, from needs, which should be defined and addressed, and overall affordability, of which there is a limit.

We at GAO look forward to continuing to work with this Committee and the Congress in addressing this and other important issues facing our nation. In doing so, we will be true to our core values of accountability, integrity, and reliability.

Chairman Grassley and Ranking Member Baucus, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee may have.

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