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ADMINISTRATION'S FY 2003 BUDGET PROPOSAL FOR PRESCRIPTION DRUGS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

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COMMUNICATIONS

ADMINISTRATION'S FY 2003 BUDGET PROPOSAL FOR PRESCRIPTION DRUGS

THURSDAY, MARCH 7, 2002

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

The hearing was convened, pursuant to notice, at 10:08 a.m., in room 215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Also present: Senators Rockefeller, Breaux, Conrad, Graham, Lincoln, Grassley, Hatch, Snowe, and Thomas.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, everybody. This is a good gathering—a chance to see old friends, compare notes this morning.

I am especially pleased to welcome our good friend and colleague, former Finance Committee member Bob Kerrey. If anyone helped enliven this committee and cause us to think a little bit, it was certainly the great Senator from Nebraska. We are very happy to see you here, Senator. I glanced at your testimony this morning, and you have not changed. I really appreciate that.

There is a lot that the committee is going to be taking up this year in the area of health and human services. We have Medicare prescription drug coverage, regulatory reform, and provider payment issues, reviewing and reauthorizing the 1996 Welfare Reform bill, otherwise known as TANF, expanding health care coverage. It is a lengthy list.

My hope is that, on each of these issues, we can truly work together and come to an agreement. It is not terribly glamorous to do so, but it is about the only way to get anything of consequence done. After all, that is what we are sent here to do.

Turning to the specifics of today's hearing, I would like to explore three different, but related, subjects. First, we will take a closer look at the administration's Medicare proposal.

The centerpiece of the plan is a short-term effort to provide immediate prescription drug relief in the form coverage for low-income seniors. It is a plan that also includes a Medicaid waiver program called Pharmacy Plus, and a drug discount card.

On the broader issue of prescription drug coverage, we are going to spend some time on what reform means. Many insist that reform must accompany a prescription drug benefit, but we all know that reform is in the eye of the beholder. It means something to some,

and something else to many other people. I think it is important to flesh that out.

I hope that today's hearing can help us learn what the administration means when it talks about reform. Now, I recognize that the administration's reform program is not spelled out yet in very much detail, but nonetheless I expect that will evolve, and hopefully sooner rather than later, because we need a better sense of the administration's framework, the administration's priorities if, in fact, we are going to reach some conclusions and get something passed that makes sense.

The second purpose of the hearing is to help us write the Congressional budget by getting a sense of how much it will cost to provide a prescription drug benefit to Medicare beneficiaries.

In the next few weeks, the Budget Committee will be working on a budget framework for 2003. As part of that process, we will need to determine how much we should allocate for prescription drugs and make a recommendation to the Budget Committee, not only on prescription drugs, but recommendations related to other aspects of Medicare spending.

Last year's budget resolution set aside $300 billion for prescription drugs and Medicare reform. That was a preliminary figure. Since then, we have learned from the Congressional Budget Office that the premiums for benefits at $300 billion would be high, so high that many Medicare beneficiaries would not sign up for the program.

So as we prepare this year's budget, there is a wide range of opinion on what the budget number should be, and we have a wide spectrum of views on that.

The administration has proposed $190 billion for Medicare, with $77 billion of that dedicated to a low-income benefit. The American Association of Retired Persons, AARP, has proposed up to $750 billion for Medicare for drug benefits, and they are prepared to tell us what they think seniors want and what seniors expect from Congress.

It is my hope that this hearing can inform the debate over how much Congress should spend on prescription drugs and what we should consider in making that determination.

Third, and finally, I am very interested to learn more about the administration's new discount drug card proposal. I understand that these cards are currently available, but there might be some benefit to creating a Medicare-based program in which sponsoring organizations are screened and approved by Medicare.

Stepping back for a moment, it is imperative that we keep in mind the needs of Medicare beneficiaries, particularly those who lack coverage for prescription drugs and are financially distressed as a result of high drug costs.

We have a tremendous opportunity to make a difference and lend folks a hand. We have the responsibility to do our best to meet seniors' needs.

I very much look forward to working with the administration, members of the committee, and others on the Hill, but particularly with my very good friend Chuck Grassley, Ranking Member of the committee. As always, we have worked very closely together.

I just want to again thank you, Senator, for your cooperation and your desire to get something done. Again, thank you very much. All of us really appreciate your work.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Well, obviously, I appreciate that statement of our close working relationship. I would associate myself with your remarks and, in turn, thank you for your remarks, and more importantly for this meeting. Because you cannot start the issue of prescription drugs too soon, and to do it this early in the year, I want to thank you for doing that.

I also thank our witnesses who have worked hard to be here today, more importantly, to be prepared to have an exchange of views with us. I know that you were invited just a short time ago and had to rearrange schedules to be here.

And particularly to our friend, Senator Bob Kerrey, for his response. Even though he has left the Senate, his appearance here still reminds us of his long-term commitment to public service, and we thank you for that.

I also want to thank AARP for having Bill Novelli respond to our request that he appear and be on the panel as well.

I take this opportunity to applaud President Bush for his commitment to making Medicare a better service for our beneficiaries. The biggest flaw in Medicare today is its failure to cover prescription drugs. That one thing, when it is done and done right, will bring Medicare into the practice of medicine in the 21st century as opposed to 1965.

Now, we all know that the President highlighted this during his campaign, and I am glad that he kept that commitment last year, with a better proposal for this year. But, more importantly, it is a signal to all of us that he is willing to work for yet an improvement on what he has suggested.

Considering the fact that Congress has not acted on these issues, I want to emphasize that a meeting like this, or any meetings on this discussion, should not denigrate the President's proposal, because he is out there on paper, where Congress has failed to act.

Now, obviously I think we should go much further than the President goes, but the President has a program. So, we in Congress ought to be looking at our inaction rather than what we consider an inadequacy of the President's program.

The President has done his part by making practical proposals to get the process started towards comprehensive benefits and has made it clear that his proposals are a starting point, not some sort of take-it-or-leave-it proposition dumped on the door of Congress. So let us be reasonable. Let us sit down and work together instead of simply rejecting his efforts to reach out.

Will we achieve a comprehensive new drug benefit this year? Well, I obviously hope so. But there will always be the temptation to let the best be the enemy of the good.

I know there are some members on this committee, and off of it, who say that we have to spend $750 billion on a drug benefit. Well, anyone who says that simply has their head in the sand.

In fact, I have reviewed the comments of many members, both on this committee and off the committee, during last year's budget debate when so many of us in both parties said that about $300 billion was what was needed to provide a decent drug benefit.

Well, drug costs have increased since last year, but they certainly have not gone up 150 percent. So, let us get serious about this issue, get down to business. The key to finding agreement is being reasonable and meeting in the middle. Let us do that and see what we can get done.

In terms of Congressional action on a drug benefit, several crucial developments are coming up in the next month or so. The first is the budget process. Last year, I was pleased to work with Senator Snowe to create a $300 billion reserve fund to improve Medicare, including adding drug benefits.

Whether both Houses of Congress will be able to agree on a budget resolution by the April 15 deadline this year is an open question, I believe. But if we are not able to get a budget, then the $300 billion figure will remain in force. So that number may continue to be a very important one, and we will know more by or around April 15.

Another critical factor in the next month will be the Congressional Budget Office's input on the cost of prescription drug proposals. Today, I believe that Director Crippen is starting this process by presenting the CBO's new projections of drug spending.

In the following weeks, that organization will be re-estimating existing proposals which will set the stage for scoring new ones. Between this effort and the budget process, it will become very clear in April what parameters this committee will need to work within.

Now, as you know, some of us, three or four different groups on this committee, sometimes consulting, sometimes not consulting, are working to develop a comprehensive bill to strengthen and improve Medicare.

The group I am part of is meeting and consulting very regularly. We include in our proposal a prescription drug benefit that is affordable to beneficiaries, and also something we forget, that is affordable to the Nation.

I appreciate Senator Kerrey's reminders of the big picture of Medicare and the Federal budget as a whole. That we ought to focus on drug benefits in isolation by itself would be an irresponsible luxury, one that the Nation cannot afford.

Now, Director Crippen's testimony reminds us that drug costs are growing explosively and that we must make sure that any benefit is delivered in a cost-efficient, competitive manner. We owe it to all Americans to make sure that there is no waste in the new Medicare drug benefit.

Another thing that we must do is to ensure that the drug benefit works just as well for beneficiaries in rural America as it does for others. This is something where I do not think Senator Baucus and I ever have any disagreement on.

Rural seniors cannot afford for us to repeat the mistakes of the past with payments or delivery systems that discriminate against low-cost areas. Any bill I am involved in will definitely be one that works for rural America.

By the way, while the existing Medicare fee-for-service system is not the focus of this hearing, I will make it clear that I will be fighting for more equity in Medicare payments this year. For the people I represent, that is just as much a part of strengthening and improving Medicare as adding a drug benefit.

Finally, let me note that I was pleased to learn from Director Crippen's testimony that Medicare spending is now projected to be $80 billion lower over the coming decade than was previously projected. As far as I am concerned, that money should be spent on Medicare beneficiaries and not for other purposes.

Thank you.

The CHAIRMAN. Thank you, Senator.

I will now open it up for very brief statements from members of the committee.

Senator BREAUX. I will have some comments later, Mr. Chairman.

The CHAIRMAN. All right. Senator Conrad, Senator Graham, Senator Thomas?

Senator THOMAS. I will have some questions later. I just wanted us to take a long look at how we deal with this in the long term, that we kind of have an idea of where we want to be 20 years from now. The cost problems are there. It is easy to say, well, let us just put more money into it. We need to kind of look a little deeper than that as to why it is there and what we can do.

I want to echo Senator Grassley's comments about rural areas. So, thank you for having this meeting.

The CHAIRMAN. All right. Mr. Scully, you are on deck.

STATEMENT OF HON. TOM SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Mr. SCULLY. Thank you, Mr. Chairman, Senator Grassley, and Senators, for having me here.

The CHAIRMAN. It is good to see you. I know how hard you work, and we deeply appreciate the service that you provide to the administration, this committee, and to the country.

Mr. SCULLY. Thank you very much. I hope my wife is watching so she will know where I am. [Laughter.] Thank you.

I asked Bobby Jindal, who most of you know is our Assistant Secretary of Planning and Evaluation, to come today as well to help out. Bobby is the administration's expert on Medicare.

We work closely together on everything, but when I was asked to testify today, I thought it would be helpful to have Bobby along to talk about the broader scope of overall Medicare reform, which we are obviously very committed to.

Let me just start by saying that along with, I think, almost everybody on the committee who is here today, I have worked with this many on this committee and the AARP in 1989 in my first job under President Bush 41 to try to save catastrophic in the spring of 1989.

So I am particularly frustrated that it has taken 13 years and lots and lots of well-intentioned efforts to get back to where we are, which is, I think, what seniors really want, a meaningful, hopefully well-structured Medicare drug benefit and a reformed system.

I believe we can have a healthy debate about what we should do over the next decade, whether it is $150 billion, $190 billion, $300 billion, whatever the number is. I think the frustration many people feel with this issue, is in the last 15 years many ideas have been kicked around, but absolutely nothing has happened.

We look at this as a multi-year project that requires a lot of building blocks. Senator Graham, Senator Breaux, Chairman Thomas, and many others have worked on Medicare reform proposals for the last number of years that all have great ideas, but we believe it is time to just find a way to sit down, work it out, and get something done.

There are many things, like the drug card that you talked about this morning, the low-income subsidies, and other things that we think are short-term steps to get the ball rolling this year, immediately.

There should be no doubt that the President and the Secretary are totally committed to Medicare and having a meaningful prescription drug benefit for American seniors and people with disabilities.

The President wants this to happen now and wants us to use this year to get started immediately with these building blocks that I mentioned.

I think it is crucial, as Senator Grassley said. We really want to sit down and work with you. We really do not intend to send up a proposal that says "take it or leave it." We would like to sit down and work this out this year. We understand that it is going to take a lot of bipartisan work to get there.

To that end, I want to discuss three things that we think are crucial building blocks to get going. The first one, is the Medicare prescription drug card. Ten million Medicare beneficiaries have no prescription drugs at all; about half of those, or 5 million, are people below 175 percent of poverty.

We find it particularly frustrating that the only people that walk into a drugstore to buy prescriptions these days that pay full, over-the-counter prices and have no bulk discounts and no negotiated discounts tend to be the uninsured and seniors. A lot of these seniors are low-income seniors.

The President's proposal on his drug card is pretty straightforward and pretty simple. It is a pooling mechanism. It is obviously not a subsidy, it is a pooling mechanism to try to get the 40 million we have in the Medicare program into group purchasing pools to try to get negotiated discounts.

It is very common, basically, to what almost everybody in this room has who is under 65, whether you are in the Federal Employee Health Benefits Plan or in any private insurance plan.

Virtually every privately insured person in this country, if they pull out their insurance card, at the bottom it says, "Express Scripts," or "PCS," or someone else, and they are getting pooled discounts.

We know this is not what seniors want. We know it is not the end result anybody wants. But it is a big first step. Getting these 40 million people into groups to buy in groups of hundreds of thousands instead of groups of one is a big step forward.

It is a key proposal, a key portion of Senator Breaux's proposal, Senator Graham's proposal, Chairman Thomas in the House's proposal. Every major proposal between 35 and 60 percent of the savings you get in these drug proposals comes from putting people into group purchasing.

We believe it is just a fundamental issue. We can discuss what the appropriate subsidy is and how to set it up, but the first step is to say, let us get the 40 million people that we have in the program and use them to get better discounts, and use their market leverage.

We do not think it should be particularly controversial. It is just common sense and is a good first step to get going.

The President's proposal for Medicare would endorse a number of discount cards operated by private organizations. It is an attempt to mimic what goes on in the under-65 market.

As GAO did a study a few months ago, in the over-65 market there are plenty of plans. There are plenty of plans in the over-65 market, but they really do not have market clout. This is really an effort to do the best we can to mimic the under-65 market.

Seniors would be required to pick one card that is certified by Medicare for a period of 6 months, with a maximum one-time enrollment fee of $25. I know of at least two companies that plan to have no enrollment fee.

Is this a new benefit? No. Is it perfect? No. But it is a key component of getting started and we think it is the first step towards using our 40 million seniors to start getting group purchasing discounts, then we can all discuss what the appropriate subsidy beyond that is.

The drug card has another important aspect to it that a lot of people miss, but I think is one of the key reasons I believe that AARP has been so supportive of it. That is that CMS is going to likely be required to run this program, and we have absolutely no experience in running a drug program.

While almost every major bill—Senator Graham's, Senator Breaux's, or Mr. Thomas'—all would take two or 3 years at minimum to start, we have to figure how to run a drug benefit.

Starting with a voluntary drug discount card now would allow us to lay the infrastructure to figure out how to actually pay pharmacists, get discounts on drug companies, and lay the infrastructure to figure out how to actually run a full-scale drug benefit program, which we have absolutely no experience doing.

So we believe it is a crucial first step. It is not perfect. It is no intended to be a drug proposal. It is a discount proposal to get us started.

The second step that we think is important, is we believe we have a lot of poor seniors that immediately need help on drug cards. You mentioned, Mr. Chairman, $77 billion. Actually, that is the 10-year cost. We actually look at it as a 3-year proposal of about $8 billion to get started so it can get folded into a longer-term reform proposal.

But we think it is critical that up to 150 percent of poverty, which is only about $17,000 for a family of two, that we immediately start giving those poor seniors access to a real drug benefit.

What the plan would basically do, is utilize the existing Medicaid program in States, or if you have a private program, like West Virginia, has a Mountaineer Program, Iowa has a program. It does not have to be through Medicaid, it can be through any mechanism.

If a State wants to sponsor a low-income Medicare drug benefit, we will pay for 90 percent of the costs for the seniors between 100 and 150 percent of poverty. We believe that will be a significant injection of funding to immediately help low-income seniors, which is the critical population that needs help the fastest.

For example, we are trying to work for States that are not even waiting for that to be enacted. In the State of Illinois, we approved, about a month ago, a waiver to cover every senior in the State of Illinois up to 200 percent of poverty. That is 368,000 poor seniors that will immediately get coverage under a Medicare drug benefit, and we have done that through a waiver in their Medicaid program.

But we are interested in sitting down with States to try to mimic what we have done in Illinois as well and as quickly as we possibly can.

The third, final, and probably most important building block, is to work with all of you to come up with a really long-term restructuring of the Medicare program to make the Medicare program work better.

We really believe that anybody in the Senate, Republican, Democrat, or Independent, probably would not sit down with $255 billion and restructure the Medicare program like the one we have today.

The President is determined to get through the previous log jams on Medicare reform and come up with a reformed Medicare program and a prescription drug program. We have strong feelings about how it should be laid out, but we are determined to work in a bipartisan way to get this done.

Just for example, one of the things that really needs to be changed is the Medicare Plus Choice program. Whether you like Medicare Plus Choice or not, the number of people that are in that program tend to be disproportionately poor.

They have the option of choosing a slightly tighter network in exchange for much lower co-payments and deductibles, usually, and traditionally a better drug plan.

As that program has basically been frozen for the last 5 years, what has happened is the poor seniors who disproportionately use that program have had much higher co-payments, much higher deductibles, and their drug benefits have been quickly disappearing.

So we think we need to fix Medicare Plus Choice, and it has to be part of a reformed Medicare program. We also think that if we are going to add a drug benefit to Medicare fee-for-service, which we said we are willing to talk about, it has to be one that is reformed and restructured as well.

Two-thirds of seniors either have a wrap-around retiree program or Medigap program. Once they send their check off to Medigap, whether it is Blue Cross of Louisiana or Blue Cross of Montana, they are generally totally insensitive to their costs.

We believe we need to restructure Medigap, have some modest co-payments and deductibles for people who are not poor, and in

exchange for that rationalize the behavior in the program to give people the opportunity to have a more rational structure in the Medicare program and to make the drug benefit part of a more rational Medicare system because right now we believe the incentives in the traditional Medicare fee-for-service are not right.

The President said in his principles that every senior, if they want to keep the existing Medicare program as it is with the fee-for-service structure it has, great. We would like to let them keep it.

But going forward, if we are going to add a drug benefit to a fee-for-service structure, it should be a reformed fee-for-service structure and it should be part of reformed comprehensive Medicare program.

Let me just wrap up, Mr. Chairman, because I am sure I have already gone way over my time, we are really committed to getting this done this year. Senator Breaux and Senator Kerrey were two members of the Medicare Commission, Bobby, as you know, was the staff director.

I think everyone was frustrated with the log jam that we had 4 years ago in the Medicare Commission and I think people in both parties are truly committed to doing the right on Medicare reform and prescription drug. The administration is completely committed to getting this done this year.

I think the only thing we find unacceptable is the status quo. We certainly have strong feelings about trying to do this through the private sector mechanisms, but we are very anxious to sit down this year with the committee and start to work on short-term fixes for prescription drugs and longer term significant restructuring of the Medicare program. Thank you for having us.

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

The CHAIRMAN. Thank you, Mr. Scully.

First, I just want to thank you for sending us a big box of materials that arrived about 9:00 this morning in response to an October 12 letter asking for the information. As you know, the material revolves around the administration's change in Medicaid waivers. There are a lot of changes.

The process is not a very public one, which is contrary to precedent. There are a lot of policy issues that revolve around the administration's issuance of these waivers, which have sweeping consequences. But thank you very much for sending us this information.

Mr. SCULLY. Well, Mr. Chairman, number one, it is not a good excuse, but I did not know about it until Liz called me on Tuesday.

The CHAIRMAN. All right.

Mr. SCULLY. So when she mentioned it on Tuesday, we did the best we could to get the information over.

The CHAIRMAN. I appreciate it. Nine o'clock is better than not at all. I appreciate it.

Mr. SCULLY. I apologize. I was not even aware that you had sent the letter. I should have been.

The CHAIRMAN. Mr. Jindal, I understand you are going to speak for a few minutes.

STATEMENT OF BOBBY P. JINDAL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. JINDAL. Thank you, Mr. Chairman. I will keep my remarks short.

Mr. Chairman, Senator Grassley, distinguished committee members, I am pleased to be here this morning to discuss the President's approach to strengthening Medicare.

Tom has submitted his statement for the record, but he did ask me to join him so that I could summarize the administration's overall vision for an improved Medicare program. He has discussed a number of initiatives to provide immediate help to seniors with their drug costs and other options.

We believe these immediate steps should be integrated in Medicare legislation, both for their own sake and also because they will pave the way for a full prescription drug benefit and the other improvements that Medicare needs.

This committee obviously played a key role in creating the Medicare program. When that legislation was enacted, President Johnson said, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime."

Thirty-six years later, President Bush believes that it is time for our Nation to come together and renew that commitment. Secretary Thompson, Tom, and I share the President's view that we have a moral obligation to fulfill Medicare's promise of health care security for America's seniors and people with disabilities.

Medicare has provided this security to millions of Americans since 1965, but its lack of prescription drug coverage demonstrates that Medicare is not keeping up with the rapid advances in medical care. Looking ahead, medical care holds a promise of improving and extending life through countless innovations.

As we enter the 21st century, Medicare's promise is threatened by outdated benefits, limited financial protection against high medical cost, a system that has not delivered reliable health plan options, and a traditional government plan that often fails to deliver responsive services to beneficiaries or ensure high-quality care.

The 77 million Americans who will be entitled to Medicare in 2030 are counting on Medicare's promised benefits. Yet, even Medicare's current benefits are not secure for the retirement of the baby boom generation. Medicare's fund for hospital insurance will face cash flow deficits beginning in about 15 years, and is projected to become insolvent within 30 years.

Medicare's funds for its other benefits will require nearly a doubling of beneficiary premiums and infusions of general revenues to remain solvent just over the next 10 years.

Medicare's accounting currently masks the true fiscal health of Medicare and makes it difficult for us to plan ahead. Recognizing these problems, President Bush has worked with members of Congress from both parties to develop a framework for a modernized Medicare program and for keeping Medicare's benefits secure.

The President's framework includes the following principles. First, all seniors should have the option of a subsidized prescription drug benefit as a part of modernized Medicare.

Second, modernized Medicare should provide better coverage for preventive care and serious illnesses. Third, today's beneficiaries and those approaching retirement should have the option of keeping their traditional Medicare plan with no changes.

Medicare should also provide better health insurance options like those available to all Federal employees. Medicare legislation should strengthen the program's long-term financial security.

The management of the government Medicare plan should be strengthened so that it can provide better care for seniors. Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced. Finally, Medicare should encourage high-quality health care for all seniors.

In his budget in the State of the Union Address, the President renewed his commitment to provide prescription drug coverage in Medicare and to also make these other improvements based on this framework for bipartisan legislation.

The President's budget proposal included substantial added spending to improve Medicare. Looking ahead, and as Tom has mentioned, we can, and surely will, have a healthy debate about how much additional funding is necessary over the next decade to modernize Medicare and to provide a prescription drug benefit, whether it is the $190 billion proposed by the administration, the $300 billion that had strong bipartisan support last year, or some other figure.

It is important to recognize that we support a package of improvements to bring Medicare up to date, including reliable, less costly health care coverage options, an improved benefit package, and lower drug prices through competition.

Others may advocate a different approach, but we hope we can all agree that scarce funds should not merely go to crowd out existing sources of drug coverage, including the employer coverage many seniors enjoy today.

We also hope that a consensus can be reached that the drug benefit should use the most effective means to get competitive price discounts for seniors and for Medicare. We must ensure that the drug benefit enacted this year will be there for tomorrow's seniors as well as today's, and we should be able to agree, just about the design of the drug benefit, that under any proposal it would not be implemented for several years. There again, I will defer to Tom in terms of the immediate steps that we would like to take.

Let me just conclude by stressing that we are committed to working with Congress to enact legislation consistent with the President's principles so that we can have a prescription drug benefit in place this year.

We all know that failing to meet these unavoidable challenges may lead to more extreme changes later, including government controls on prescription drugs and stricter coverage limits in Medicare.

These changes would reduce access to needed treatments and slow the development in new technologies, such as promising new drugs for common cancers and other diseases.

Instead, we must come together now to make the sound, careful, and deliberate steps needed to improve the Medicare program for today's seniors and tomorrow's, and we must start the process now.

These issues have been debated on and off for years, as Tom has said, but now it is time for action. Thirty-six years from today, we should still have a Medicare program that fulfills President Johnson's promise of a secure and vibrant retirement.

Thank you, Mr. Chairman.

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

The CHAIRMAN. Thank you very much, Secretary Jindal.

One of the big questions on people's minds, I think, is how much should the Congress allocate for prescription drug benefits. The administration's suggestion of $190 billion compared to the backdrop of, say, last year we had proposals of $300–350 billion, and so forth, over 10 years.

There was a lot of concern at that point that the required deductibles, the co-insurance, and the premiums were so high that we would have another "catastrophic" debacle like many years ago when Congress attempted to pass, and did pass, catastrophic health insurance, only to find that seniors reacted violently against it and Congress repealed it.

So at $190 billion, one has to legitimately and logically ask the question, if $300 billion raised lots of questions, how in the world can there be a prescription drug benefit at $190 billion? It must mean there would have to be terrific savings from reform, and/or it means the benefits are quite low. If they are so low, then seniors might not participate and it is just a waste of time.

So my question is, are you anticipating very significant savings at $190 billion, and if so, from where? If not, why do you believe people will buy into a program at $190 billion?

CBO has said that there are not many savings already with respect to the administration's general proposal. So if we could just flesh that out a little bit, that might help advance the ball.

Mr. SCULLY. Well, there are some savings from changing the incentives in Medigap. We propose to totally reform all of the Medigap plans and put in, for the non-poor, modest co-payments and deductibles. So, there are some savings.

The CHAIRMAN. CBO says that saves about $1 billion.

Mr. SCULLY. I think ours are probably——

The CHAIRMAN. Well, in the neighborhood. Not a lot.

Mr. SCULLY. It is probably $10 billion, we would think.

But I think the issue for me, as you know, is the scoring changes every year. The CBO baseline changed last week by $80 billion. Some of the primary bills last year in the House were, I think, $156 billion. We would like to come up with a package that works, that has a reasonable health care plan with reasonable premiums to start.

But I think we are all concerned, in my opinion, I think in many others' opinions, and I am sure CBO's, that the evidence on what the drug costs are going to be, what the inflation is going to be, how the program is going to work, whether there are going to be

formularies, what drugs are going to be covered, are a lot of questions. We clearly need to do this, but the uncertainties on what the costs are going to be are enormous.

So, I think we are pretty concerned. I do not think we are structured on a particular number. We proposed $190 billion and I think we have made it pretty clear that we are willing to talk about a lot of different options.

But we are focused on trying to come up with a benefit that we can start now, get into, figure out how it works. I think most people that are serious analysts in this area think that the questions, what this is actually going to cost and where it is going to go in the next 5 years if we pass it, are many and very wide open. I think anybody who is trying to estimate in this area has a tough time doing it.

So we are serious about doing it. We think $190 billion is enough. We are willing to talk about other options. But there were serious options on the House side for $156 billion and $145 billion last year, and I think we are in the range of being very credible. I think, clearly, whether we have a 35 percent subsidy for the private premium, as the House bills did last year, or 50 percent as Senator Graham's bill does, whether you have a $6,000 catastrophic cap or a $4,000 catastrophic cap, are all things we are willing to talk about.

There are many, many moving pieces. But I think we are clearly in the range of putting together a credible benefit, but also the scoring, as you well know, changes almost by the week. One hundred and ninety billion last year versus $190 billion this year is also probably a different number depending on the assumptions you make.

I think this is a credit to the President, the Secretary, and Mitch Daniels. Every question I got before Christmas was, with the deficit we have now, is the President going to still take a significant amount of money and put it towards prescription drugs in a Medicare forum? The answer is, we did. I think it certainly was a serious commitment to doing something this year.

The CHAIRMAN. Well, I think most people would find $190 billion incredibly low, given the need that so many seniors have and how difficult it is for so many seniors to find the resources, the wherewithal, to pay for prescription drugs.

I would hope that the administration would come forth fairly quickly with some explanation as to how it expects it to work, where the savings are, and what the premiums and benefits come out to be, only so that we can know where we are as we work out this problem.

I appreciate some of the other proposals you mentioned, but it is also true that there are some very serious proposals at $500 billion, $750 billion. At $190 billion, it is about 80 percent co-insurance. That is pretty high.

Clearly, any proposal, any legislation the Congress enacts to provide for prescription drug benefits has to be something that is going to work, that works for seniors. Clearly, it cannot be a giveaway. That is true, too. There has to be some co-pays and deductibles, probably, and so forth. But then it has got to work.

So, we cannot be kidding ourselves. The way we get from here to there—it would very helpful if you could tell us what you have, and then we could see if that works and how we build from there. From the outset, $190 billion seems unworkable based upon the lack of evidence that has, so far, not been forthcoming.

Mr. SCULLY. I would make two quick points, Mr. Chairman. One, is we are dead serious about doing this, so we are committed to seeing that and working with you in getting as much technical assistance and guidance as we can, and do this as fast as we can.

Second, we are also very concerned, and it is a major part of the President's budget to do something about the 40 million uninsured. So, while we are very serious about doing something on Medicare, I think the potential costs are uncertain.

The President put $89 billion in his budget for a health credit, which I think would be a significant step toward helping the uninsured, too. I think we ought to move forward on both. So we also want to be careful that however we get started on prescription drugs, we do it in a responsible way.

But our major concern is, instead of having honest disagreements over $190 billion, $150 billion, or $300 billion, or whatever number, that we be back here in a year starting from scratch and do nothing.

I think anything we do, and we are very happy to debate a variety of numbers, but what we do not want to do is be back again next spring starting off from scratch.

The CHAIRMAN. Believe me, we share that opinion. Thank you very much.

Senator Grassley?

Senator GRASSLEY. Yes. Thank you very much.

One of our top priorities, as I said in my opening statement, is to provide an affordable prescription drug benefit in Medicare and universal access. As you said, we must also improve and strengthen the existing Medicare program at the same time. I am glad to hear you say that.

The President's budget is specific on interim steps that we can take until a comprehensive approach is put in place. It is not specific about longer-term proposals. Just this morning you said that you want to work with us in developing a comprehensive approach consistent with these general principles President Bush has put forth.

Some of us on the committee are working to develop a comprehensive and workable policy, one that is responsible and sustainable, and not just make some mere political statement.

So today, Mr. Scully, I would simply like to confirm that the administration favors a comprehensive drug benefit and Medicare improvement bill. That—not merely the interim steps of the drug card and the low-income steps—is the President's first choice, isn't it?

Mr. SCULLY. There is no question, Senator Grassley, we clearly want a comprehensive Medicare benefit. I think I can speak for myself, and my guess is for Bobby as well, it is one of the primary reasons we both came back in the government was to try to get it done.

Senator GRASSLEY. All right.

My last question is dealing with rural issues, as I so often do, related to comprehensive drug benefits as well. I want to hear more about your proposal to provide incentive payments for new types of plans like PPOs that enter Medicare Plus Choice.

Like so many other States in rural America, Medicare Plus Choice plans have passed Iowa over, claiming that low reimbursements and long regulations make it impossible to do business.

Since 1997, you know I have fought hard to give payment increases, and even bonuses, to plans in the floor counties so that Iowa seniors and seniors in other States could have the same choices as those in Florida, for instance, or Los Angeles, for instance.

But we have not been able to accomplish anything along this line, even with dramatic improvements in the floor. These plans simply, after all of that, have not come to rural America.

Will your new plan incentive proposal do anything to change this? If so, be very specific so we know how this is going to be done. I do not want to lose another four years, after we thought we had made such progress in 1997.

Mr. SCULLY. Senator Grassley, I think a lot of things we did in 1997 with the best intentions have unfortunately backfired. A lot of the goals in 1997 were to, basically, effectively for 5 years, only have a two percent cap on urban areas.

That has basically starved what had been a successful program, for instance, in Senator Graham's State of Florida, where we have lost most of the Medicare Plus Choice plans because they have had 10, 12 percent a year growth with a 2 percent cap.

So the options for a lot of seniors who like Medicare Plus Choice is becoming a far less palatable option. We have lost two million seniors in the last 2 years and a lot of health plans. The plans that are left are nowhere near as attractive.

The idea was to push it out into rural areas. The frustration for me, is there are not the networks in most rural areas or smaller towns to support managed care. In the under-65 market, staff model HMOs are fast disappearing.

The most that you have is a hybrid fee-for-service managed care plan, kind of point-of-service PPOs. Those do not exist in Medicare. In Medicare you either have kind of a closed panel HMO, for the most part, or you have Medicare fee-for-service. There is one PPO in the country.

So one of the things we have tried to do, is understand the fact that in most rural areas the networks do not exist to create managed care, and the managed care companies will not go there. So, we have tried to come up with some hybrids. We have done a number of demonstration programs. We approved seven last December in rural areas. The President's budget has an incentive in there of 5 percent.

In the first year it is 5 percent, 4 percent, 3 percent, 2 percent, 1 percent for plans coming into the new areas. We are aggressively trying to recruit point of service plans and PPOs to go in there, because we just do not think traditional HMOs are going to go in the rural areas. The structure for HMOs does not exist there.

We think what people want are hybrid plans. They just do not exist in Medicare, and we are working very hard to do it. I think

we are trying to find any creative way we can to get private health care plans and Medicare out into less urban and more rural areas. We certainly hope it is going to work. We are doing everything we can to try.

Senator GRASSLEY. I think we heard this morning from you or the administration a willingness to be very flexible and to work with us. Particularly, being flexible is very important in this area.

I just hope that we can find that same sort of flexibility on this committee and an opportunity to work together. We all have to be flexible, but I think your showing of flexibility is very helpful in this process.

Mr. JINDAL. Senator, if I could just add. One of the impulses behind the President's support for overall reform while he is in prescription drugs, as you know from your efforts, is to increase the number of options across the country in the way that the Federal employees plan does that as well.

One step to do that, is to move away from a purely administered pricing system for those plans. That is certainly one of the desires, and one of the reasons we are trying to do this in a comprehensive system, a comprehensive reform framework.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Thank you.

Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. And thank the panelists, Mr. Jindal, Mr. Scully, for your appearance.

AARP will testify later and I will have more to say about what I think about their testimony. But I want to hear what you think about it.

They will recommend that we spend $750 billion for a prescription drug program, that we pay for it out of the Social Security surplus, and that we hold off doing anything on any add-backs to providers—doctors, hospitals, home health care, nursing homes, anybody who gets anybody benefits—until they get the drug benefit of $750 billion. What do you think about that?

Mr. SCULLY. Senator Breaux, I have worked, as I mentioned earlier, a lot with the AARP over the last 20 years and I have very good relations with them. I think, as an advocacy group, they should be expected to ask for a very high number.

Obviously, the administration would strongly disagree with that structure and that number. I can understand how they would start off in that position and try to push the debate towards a large program quickly, but that is certainly not a position that we would support.

Senator BREAUX. Are you just not in a position to be supportive or do you oppose it?

Mr. SCULLY. No, I think we oppose it.

Senator BREAUX. Some have said that the answer to lower costs of prescription drugs are two things that should be adopted, and I would ask you to comment on both of them. One, is that generic drugs are a lot cheaper. Let us just use generic drugs. The second proposal, is that drugs in Canada are a lot cheaper, so let us import our drugs from Canada.

What do you think about both of those?

Mr. SCULLY. Well, generic drugs can certainly save money. I think in the private sector—as you know, I was on the board of a large managed care company for many years—I think there is no question that in private insurance companies they all use different types of formularies or different co-payments to get people to buy drugs more efficiently. I think it is something we need to look at.

You can clearly save money in generic drugs, there is no question about that. As far as buying drugs from Canada and bringing them back in, I also used to, a long time ago, work for a border State Senator. I know that is a popular issue up there. I think, in the long run, that is obviously not the answer.

Senator BREAUX. Does the administration oppose or support the importation of drugs?

Mr. SCULLY. Well, we have opposed it for FDA reasons, which is, it is impossible for us to regulate and monitor. FDA obviously decides what is safe and efficacious. There is no way for FDA to monitor and regulate drugs coming in from Canada, Mexico, or other countries.

The Clinton administration took exactly the same position, that it was not related to health policy, it was related to health safety. The fact is, there is no way for us to guarantee the safety of patients for drugs coming back in over the borders.

Senator BREAUX. On the generic drugs, is there a legitimate concern? I mean, it sounds very simple: let us all buy generic drugs. But if everybody in America buys only generic drugs, you are not going to have brand-name drugs. Generic drugs are only there because somebody produced and did the work on a brand-name drug that they could copy.

Is there not a legitimate concern that, if we all took the position we would just all buy generic drugs, that you are not going to have brand-name drugs produced, and no one buys brand-name drugs? You only get generics if there is a brand name that superseded it.

Mr. SCULLY. Well, I am a big supporter of pharmaceutical research. But, obviously, the reason we have patents is, at some point, the companies should make their equity investment back on their investment in research.

At some point, they come off patent. I think Mevacor, for instance, a major staten drug, just came off patent. I think it is reasonable to expect at some point that the public should have the ability to get lower-cost generics. I think it can clearly help, and in some cases it does.

I am not the patent expert, but I believe generally generics save money, they make a lot of sense, and most of the companies have shown the ability to recoup their investment over the life of their patents.

Senator BREAUX. With regard to the discount drug card that the administration is proposing, the General Accounting Office testified before Congress. The investigator said that, "A drug discount card of the type proposed by the President has not significantly cut costs for elderly consumers buying the brand-name medicines in metropolitan areas, where the savings averaged less than 10 percent of the retail price."

The General Accounting Office report said that, for people using the discount cards, the average price for 12 of the most widely-used

brand-name drugs was $62.94, which is 8.2 percent less than the average of $68.58 charged in the retail pharmacies in Seattle, Chicago, and Washington where the study was done.

I think the administration is saying that you could see a savings of anywhere from 10 to 25 percent, but the General Accounting Office, in looking at the initial discount drug plan, says you are not going to get those kinds of savings.

The point of concern that I have is that, if a person cannot afford a prescription for $68, they are not going to be able to afford a prescription for $63. The discount, while it is well-intended, is not going to have a savings that is really, truly going to be helpful to the people who need the help.

Can you comment on that?

Mr. SCULLY. I think that is a critical point. We think GAO is wrong. I called them the day the report came out and told them that they looked at the wrong thing. We asked, and I believe some other members have asked, them to do a further study.

What GAO looked at was the existing voluntary prescription drug cards in the over-65 market, which is very definitely what we are not trying to mimic. Many seniors will go out—and we have spent a lot of time talking to the AARP, who is the biggest.

If you ask a senior, they may have a Walgren's discount card, and a CVS card, and an AARP, and five or six, but none of them can really get any significant negotiated discounts from the manufacturers.

They basically get a 5, 6, 7, 8 percent discount because the drug stores, understandably, will give them a card and they will walk in, and hopefully get more volume in to the pharmacist to buy more laundry detergent. What we are very firmly trying to do, is mimic the under-65 market, where insurance companies pool people together.

The difference between our card and the existing system, is a senior can only have one for 6 months. Our belief is, if you are in New Orleans, right now a senior might have five or six cards, but none of those cards have the market clout to go back to the manufacturers and ask for a discount. We believe that Medicare has enough credibility, and if a senior could only pick one card for 6 months, we think we have significant marketing power through our 1–800 number and our ad campaign to get seniors to sign up in large numbers.

In New Orleans, if there were, say, five cards offered and you had 100,000 people in each one, they could then go back and say, we have 100,000 lives, we can move volume, we can generate discounts. I believe GAO looked at precisely the wrong thing. That is exactly what we are trying to fix. We are trying to pool real market power, and the existing over-65 market does not.

So, I have great respect for GAO, but as soon as I saw the report I called them and said, we wish you would look at the more appropriate comparison, which is what happens in the commercial market with insurers who are under 65.

Our estimate is 15 percent. We do not think we can totally mimic the fully insured market, but we think we can do significantly better than the existing voluntary seniors cards.

Senator BREAUX. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Thomas?

Senator THOMAS. Thank you, Mr. Chairman.

This is kind of new to me compared to the rest of you who have been working on this for a long time. If you looked at where we want to be 20 years from now in terms of the kinds of programs we have put together, how do you see this? Do you see us just continuing to have a 15 increase in health care and we are going to find some way to pay for it? Is that the way we do it?

Mr. SCULLY. Well, Senator, we have a lot of problems with health care costs. Believe it or not, actually Medicare has done significantly better than some other sectors because we have had the ability to fix prices in recent years.

But I think the administration's position, and obviously we stay on our flexibility on this, we envision a plan that looks more like what Senators have. We would like to have Medicare beneficiaries eventually be in more of a Federal Employee Health Benefits model, where they have a selection of a number of private health plans, one of which would be a traditional Medicare fee-for-service plan.

So, if you wanted to pick the one that my agency runs as an option, you could pick that option and the government would, in fact, set the prices for all of the hospitals and physicians in the country, as we do. Or you would have the option of going out and buying Blue Cross standard option, or maybe seven or eight other plans in your area.

That is our vision of where we would like to see Medicare go in the next 8 or 10 years. But clearly, that is a major philosophical disagreement that caused the Medicare Commission to melt down, and we are trying to find a way to constructively bridge that gap. Is that fair to say?

Mr. JINDAL. Yes. And I think it is instructive to look back 35 years ago when Medicare was created. I think you are right to look 20 years from now. What we are trying to do with the President's framework, is have a Medicare system and a health care system that is nimble enough to respond to the changes in technology and the new innovations that will be coming.

If you were designing Medicare today as opposed to how it was designed 35 years ago, prescription drugs would be a part of the benefits package.

Looking forward, as Tom has mentioned, part of the President's framework is empowering the beneficiaries so they have more choices, they have a more flexible program that is responsive to their needs and is not entirely governed by administered pricing.

We think not only will that increase quality and access to these innovation technologies, we also think it will help control costs. We think that will result in significant savings as well.

Senator THOMAS. What is the relationship—and this is very general—between the increased costs to consumers on pharmaceuticals and increased utilization? Is there some relationship between those two things?

Mr. SCULLY. The increased utilization of pharmaceuticals?

Senator THOMAS. Yes.

Mr. SCULLY. It is actually inverse. The increased costs, the less insured you are, obviously, the far less consumption. So seniors that do not have Medigap coverage, which is pretty weak drug coverage, seniors that do not have any kind of employer drug coverage, they tend to utilize drugs less, which is obviously the problem.

The poor seniors utilize drugs the least. Minority seniors utilize drugs the least. They all have equal health problems, but the lower your income and the less the coverage, the less utilized. So if you are over-insured, you over-utilize, arguably.

Senator THOMAS. Yes. It is interesting. But some of the other costs are staggering sometimes. We were talking with and meeting with some of our rural folks. Things that physicians pay, for example, for liability insurance. It is out of sight.

We do not talk much about the cost, we talk about who is going to pay for it. It seems like that is part of the problem. How do you see this pharmaceutical card thing fold in to an overall change in Medicare?

Mr. SCULLY. We have tried not to over-sell it, and for whatever reason it has gotten a lot of attention. We believe that, fundamentally, every major Medicare forum that talks about prescription drugs talks about Senator Graham's bill, as I mentioned, and talks about buying drugs through Medicare in bulk.

Right now, every senior, unless they are in an employer-based plan, buys drugs in groups of one. So we believe that, before we get into a discussion of what the right subsidy is—I mean, I use the example that I take Lipitor.

I pay a $20 a month co-payment for it, but my PBM, Blue Cross of Virginia, actually gets a discounted price of about $100. If my mom walked in behind me, she would pay $150. So, clearly, what seniors want is they want to pay a $20 co-payment.

But as a first step, we should at least give them the bulk purchasing power to get the discounts that most of us get through private insurance plans. We look at it as a rational first step to get going and then we can have the discussion about what the appropriate Federal level of insurance subsidy is.

Mr. JINDAL. Senator, just to continue on Tom's answer. The administration does believe in using the private sector tools that are available. The thinking is, when we do have the low-income subsidy, or the cash-back, or whatever subsidies, we can build on the infrastructure by using private sector tools, the discount card and other private insurance mechanisms used.

Senator THOMAS. I see. I suppose it is a little provincial, but people in small towns, of course, would like to continue to have pharmaceuticals available in their local drug store. As you do this, are they going to be able to operate in the same fashion, do you think, and how do you ensure that?

Mr. SCULLY. I think, obviously, the reason we have not gotten a drug card yet is because we actually were, as you know, sued by a couple of different pharmacy groups who were concerned about it. We put out a rule the other day and we have been enjoined from going forward with it. We certainly respect the judge's opinion. We hope we have the legal authority to go forward, and we think it will be helpful.

I think the number-one concern that most of the pharmacies had, and we are very sensitive to the pharmacy concerns—well, obviously our primary concern is saving seniors money, but we certainly do not want to do it at the cost of hurting pharmacies. Their primary concern has been the move towards managed drug benefits, and it tends to push people towards mail-order pharmacies. We do not think that is going to happen.

All of our drug cards require that you cannot participate in the program if you only have mail-order, and we are certainly very sensitive to that. They are also concerned that the rebates will not be passed to the seniors, that the middle men insurers in this area, the PBMs, will keep the money and not pass on any rebates.

Our new regulation basically requires that the rebates or discounts be passed through, and we are very anxious to work with them. We have a 60-day comment period on the regulation and we are happy to sit down with them and see if we can come up with a way to resolve more of their concerns. But the number-one issue for us is saving seniors money, and we would like to work it out in a way that makes the pharmacies comfortable.

The CHAIRMAN. Thank you.

Senator THOMAS. And other people like to have them handy that way. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman.

Thank you for being here, Mr. Scully and Mr. Jindal. We appreciate your appearance. Mr. Scully, I have worked closely with you over the years. I have got, as you know, high regard for you personally.

I must tell you, I have got low regard for the budget the President has sent up here. It is almost surrealistic, I think, looking at this budget. It does not add up. It does not come close to adding up. In fact, the whole conversation has become, to me, virtually surreal.

Let me put up a chart that shows where we have come from and where we are going under the President's budget plan. Back in 1992, we had massive budget deficits and we, through very difficult choices, climbed out of that pit, the 1993 budget plan, the 1997 budget plan, and we got in a circumstance that we were not using Medicare and Social Security trust funds to pay for other things. We did that for a couple of years.

Now under the President's plan, we are plunged right back into the abyss. Unlike his State of the Union message where he said it was going to be deficits that were going to be short and small, short-lived and small, it is just not the case.

Unless he has taken Social Security and Medicare trust funds forever more, which his plan advocates, what we see is red ink forever. At no time in the next decade does he stop raiding trust funds to pay for his tax cut in other spending.

So let us go to the next chart. Last year, we were told that, over the next decade, there would be $2.7 trillion of non-trust fund surpluses. $2.7 trillion of non-trust fund surpluses. That is where his tax cut was financed out of.

What a difference a year makes! Now there are no non-trust fund surpluses. Instead, there is $2.3 trillion of non-trust fund deficits over the next decade. $2.3 trillion. That is real money. We see that right at the time we are headed into the retirement of the baby boom generation.

It is possible to engage in this kind of funny money accounting until the baby boomers start to retire, then everything changes. Then instead of the trust funds throwing off big surpluses that are able to be used to finance tax cuts and other spending, all of a sudden that game is going to come to an abrupt end. In 2016, those trust funds turn cash negative.

The President is doing nothing to prepare us for that day. Even worse, he is digging the hole deeper. He is saying, in his budget plan, just go right ahead. Take $2.3 trillion out of those trust funds and use it for tax cuts, use it for other things.

In fact, the testimony yesterday at the Congressional Budget Office was, the size of the tax cut that he pushed and got through Congress is virtually identical to the Social Security trust fund deficit over the 10 years. The deficit, if you are not using Social Security, is $1.8 trillion over the decade. The tax cut, including the interest costs, is $1.7 trillion.

So the President has taken us down a path that does not add up, that is going to make the choices for the future far more difficult. What we know, is a future president and a future Congress is going to have to have massive benefit cuts, huge increases in taxes, massive debt, or some combination.

I mean, that is the stark reality of where we are headed. I see nothing from this President other than, dig the hole deeper. He comes before us this year, let us do another $600 billion of tax cuts and dig the hole even deeper.

My question to you would be, can you explain to me how this all adds up?

Mr. SCULLY. Well, Senator, as you know, I think I knew you originally from my previous life at OMB. I can say that, in this circumstance, I am thrilled I no longer work there. I have no doubt that you and Director Daniels—I have not followed it closely—have had a running debate.

I have been involved on the trust fund debates and how they should be counted for years. I am not sure it is probably appropriate for us to jump into it. It is a much larger budget context discussion. But I do think it points out the need, overall, for being careful fiscally about what we do on prescription drugs, the uninsured, and other things.

Creating new entitlement programs, unless you are certain what the results are going to be—and we are very strongly in favor of a new Medicare drug benefit and doing things for the uninsured. Obviously, those assumptions are without any new program spending. So, it certainly would, I think, lead to the conclusion that new program spending should be done in a way that keeps all these budget figures in mind.

Senator CONRAD. Let me just say that I think this town is totally divorced from reality. That is why I believe. That should caution us.

The CHAIRMAN. Thank you very much, Senator.

Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

I do not have such a statistical argument to make as my friend Senator Conrad has just done, but rather one of policy and what constitutes real reform.

I am concerned when the subject matter is stated, as you did a couple of times, Tom, as being a prescription drug benefit and Medicare reform, as if those were two separate subjects.

My own judgment is, the most fundamental reform that Medicare must make is the reform that will move it from being as it is today, essentially a sickness program, a program that will provide benefits only when you are ill enough to go to a doctor or even into the hospital, with limited exceptions, into a program which has as its primary orientation wellness and those things that will prevent illness and maintain a high level of good health.

In almost every one of those modalities that will prevent and maintain good health, prescription drugs play a critical role. Therefore, when we talk about, what is real Medicare reform, I think real reform is to have a system that focuses on good health. That puts prescription drugs not on the periphery, but in the center of that reform effort.

So, with that statement of my personal philosophy of what it is we are about, I share the concerns that have been raised about the level of funding that the administration has proposed.

First, I would like to be sure I understand just what that level is. As I gather, there is within that $190 billion $77 billion that is a version of the 2001 immediate helping hand proposal. Is that correct?

Mr. SCULLY. There are really two points I would make. It is not the immediate helping hand proposal. It is totally different, and we designed it to be much more readily acceptable to everybody involved. We really envisioned the $77 billion in the budget was a 10-year score, and we really look at it as a 3-year program, and it is $8 billion. So our hope is to get a reformed Medicare program with prescription drugs, and that tail of the last 7 years will be folded into that.

So we really look at it, I guess, as $182 billion in the long term, and $8 billion in the short-term for the first 3 years. Before we actually get to a full reformed program with prescription drugs as a short-term injection of finances into the States, that we fund a low-income program in the transition.

Senator GRAHAM. Then out of that $190 billion, is there not another $4 billion for Medicare Plus Choice plan enhancements?

Mr. SCULLY. I do not believe that is the same. It is additional money. It is outside.

Senator GRAHAM. So the total sum available for a comprehensive, ongoing prescription drug benefit then is approximately $182 billion. Is that correct?

Mr. SCULLY. For the long-term package, outside the next 3 years, $182 billion would be right.

Senator GRAHAM. I would like to look at what some of the components that lead to that $182 billion are. What are you recommending in terms of monthly premiums?

Mr. SCULLY. Senator, to be perfectly honest, the way the plan was designed was to add into a comprehensive reform plan the ability for people to buy private health insurance. In our view, that would be flexible as to what the monthly premiums, the deductibles, the co-pays, and the coverage would be.

Senator GRAHAM. Well, let me ask this question. What do you anticipate to be the overall percentage of the cost of this new program that would be paid by the beneficiaries and how much would be paid by the Federal Government?

Mr. SCULLY. We have not calculated that. I can say that, in the range of plans that were looked at last year, and I think the scoring changes, you could probably look in that range probably for non-poor people because poor people obviously would be fully subsidized, I think the range that that finances is probably for a generic package. Again, there are a thousand variables. It is probably 35 to 40 percent.

Senator GRAHAM. Would be the Federal share, and the balance would be the share paid by the beneficiaries.

Mr. SCULLY. Of the private premium. I think that is the ballpark of what those proposals financed.

Senator GRAHAM. When do you think you will have some of the details on issues like co-payments, monthly premiums, level of catastrophic coverage, and the degree of universality of coverage?

Mr. SCULLY. Two quick points. One, is we have tried not to come up and lay out—this is where the administration is—very specifically. We would be happy to talk to you about that, but somehow that locks people into the debate. We have tried to say, you have a very responsible plan. We do not agree with all of it. Mr. Thomas has one. We would like to sit down and work out the details with you.

I think one thing that a lot of people missed last summer, and I have not had a chance to talk to you about it. I have talked to some other Senators, Senator Rockefeller. The thing that melted down the Medicare Commission 4 years ago was that Republicans, generically, Senator Breaux, Senator Kerrey, and some others thought that we should have a Medicare Plus Choice private sector health plan only, and you only get a drug benefit if you go into the new Medicare program.

Generically, the other six members of the Commission said, we want to keep Medicare fee-for-service as it is and add a drug benefit. I think one thing a lot of people noticed last July, that the President announced, was he was willing to go up to the third tier.

Any senior that wants to stay in Medicare fee-for-service can stay in Medicare fee-for-service, but we do not think, under that existing structure, that we can support a new drug benefit, because that structure has some very perverse incentives.

We clearly still prefer the Breaux-Thomas, Breaux-Frist, whatever you want to call it, approach. But he also showed a willingness to say, look, if we can reform Medicare fee-for-service with more rational co-payments and deductibles, a reformed Medigap program, we are also willing to build a fee-for-service drug benefit on a Medicare fee-for-service program.

We looked at that as a very strong effort to split the difference on the sides of the Medicare Commission, because that is what the

Medicare Commission basically broke down over. We thought that was a significant effort to move the ball forward, and I do not think people thought that.

But, rather than focus on the deductibles and the co-payments, and I think you had a $4,000 catastrophic plan, Mr. Thomas had $6,000, you subsidize 50 percent of the benefit, you subsidize 35, it is a matter of how much money you put in the pot. We are happy to talk about the details on that, but we did not want to be unconstructive by sending up an administration plan that would lock us into the details.

Senator GRAHAM. I would just say in closing, I think it is going to be incumbent upon the administration to be specific. There is an old Southern saying that if you do not know where you want to go, you can take any road because it will lead there.

We need to know where you want to go at a level of detail that will engage in a serious discussion that will get to our collective objective of, in the year 2002, passing a meaningful universal, comprehensive, affordable prescription drug benefit for Medicare beneficiaries.

Mr. SCULLY. Well, we are clearly committed to working on it. I think the absolute number that is available for financing, we said $190 billion. That decision, if it were to change, is probably above my pay grade. But we are happy to work on the details with you.

The CHAIRMAN. Thank you very much, Senator. I appreciate that.

Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman. I thank you for holding this hearing today. Hopefully, it will be a platform for action on the part of Congress this year to enact an affordable prescription drug program, and also to provide for modernization of the Medicare program, if at all possible.

Obviously, these issues are not mutually exclusive, but on the other hand, I am concerned that if we fail to address Medicare modernization, we may not get any kind of prescription drug program. I hope that will not be the end result. I think, if at all possible, we need to enact a prescription drug program.

Mr. Scully, I appreciate your can-do attitude expressed in your statement about the fact that, do not let people tell you that we cannot enact a prescription drug program this year. I would concur.

Although, it is interesting to note, in your statement you say, but for the last 20 years, you have been making that statement with respect to that, and also providing access to health insurance. So, that is the bad news. It has taken this long, obviously, to, I think, reach critical mass on the need for this kind of program.

I would like to stand up first and weigh in on the issue of cost. I share the concerns that have already been raised by my colleagues on the committee about the estimate offered by the administration of $190 billion for a prescription drug program.

I think, to be realistic, obviously, if you are looking at all the other programs, the estimates that we can anticipate in terms of cost over the next 10 years, I mean, they do range from $190 billion by the President's proposal to up to $800 billion.

So, as we know, last year we provided a $300 billion reserve fund. I really do not think that we can retreat from that basis for

initiating a program. We know it is going to cost at least $190 billion. We know it is going to cost more.

So I hope that we could provide some reliable funds to begin this effort now, recognizing the realities of what we can anticipate for affordable prescription drug program that seniors can rely on.

So I hope that we can work on that issue in terms of the number, because I do really think that we are going to have to revisit the estimate that the administration has provided.

In terms of this transitional program, CBO estimates in their report a lower participate rate than the administration does with respect to this transitional program. In fact, they estimate about 60 percent, and the administration estimates 70 percent of Medicare beneficiaries participating in this program.

Can you account for the basis and the discrepancy in the participation rate? Also, on the basis of the generosity of benefit. They believe that the States will offer a less generous benefit to Medicare beneficiaries than what is being proposed by the administration.

Mr. SCULLY. Well, the goal here is obviously to do something quickly in the short term in the next 3 years while we create a bigger program. So, our view is, any State uptake for that—we estimate 3 million people. Our actuaries estimated that we would have a 70 percent uptake. I have not read the CBO report, but if they estimated 60, I am sure it is just an honest actuarial difference in what they think the result will be.

We believe that if we are paying for 90 percent of the program, which is what we have suggested to Finance, that a lot of States that will take it up. There are a lot of States like West Virginia. Senator Rockefeller's State already has a pretty significant Mountaineer plan.

If we agreed to pay 90 percent of the costs for seniors up to 150 percent of poverty—our expectation is that the States probably would like us to pay 100 percent—an awful lot of them will take us up on it.

Senator SNOWE. Well, CBO anticipates that the "prescription drug benefits typically offered by the States would be less generous than those provided in existing State Medicare programs."

The administration's estimate incorporates the assumption that drug benefits provided under the proposal equal average drug spending to the overall Medicare population, as calculated by the Center for Medicare and Medicaid Services.

So, obviously, there is a difference in terms of assumptions here. Obviously, that will affect the level of participation by low-income seniors.

Mr. SCULLY. It could. But I would say, $3 billion of new spending to low-income seniors, if 60 percent of the seniors between 100 and 150 percent of poverty that have no drug coverage now got it instead of 70, in the short term for the next 3 years, I would be relatively happy. I hope it is 70. I hope it is 90. But I think, in any case, there will be an awful lot of seniors in the next 3 years covered by prescription drugs that are not today.

Senator SNOWE. Costs to the States. Do you have any estimates of the costs to the States in terms of their cost sharing?

Mr. SCULLY. It depends on where they are. Some States would benefit significantly because some States cover a large chunk of

seniors between 100 and 150 percent of poverty. We would basically be buying them out and they would spend less money.

I think every State but one is above 75 percent of poverty for seniors. Those States would have to put up a 10 percent match for the additional money, as well as fund their States up to 100 percent of poverty.

So we estimate total spending as $3 billion. I actually do not have the number for the States, but I think it is probably 10 percent of it or less. There are a number of States like Pennsylvania that are already up there and we will be effectively buying out their existing program.

I am sorry. It is three million people. It is $8 billion. I am sorry. I apologize. It is $8 billion. We expect three million seniors to be covered, and it is $8 billion over the first 3 years.

Senator SNOWE. And how many States, do you anticipate, would participate? Do you have any estimates on that?

Mr. SCULLY. There is only one State that is below 75 percent of poverty. There are about 15 that are above 100 percent of poverty. We expect most of those would. I think we estimate about 35 States, was our assumption.

Senator SNOWE. And you think it will take the better part of 3 years to transition into a permanent prescription drug program as part of the Medicare system? Do you think it is going to take that long?

Mr. SCULLY. Last year's bills start in 2005. Almost every major bill basically starts up in 2005. We have no experience running a drug benefit, so we believe it would probably take that long for us to figure out how to do it.

Senator SNOWE. On the prescription discount program and the card program, as Senator Breaux indicated, there are some differences in projected savings for seniors. Obviously, the administration is taking a far different approach this year in sort of consolidating the cards, and obviously the purchasing power of seniors.

Can I ask the question, Mr. Chairman?

The CHAIRMAN. If you could ask it in about five seconds.

Senator SNOWE. All right. Thank you.

So I guess what we need to have, the committee, is concrete details as to how you expect this program to work and what kind of savings the seniors truly will realize under this program. Also, having disclosures by manufacturers in terms of discounts so that we have a true sense of how this program would work. It would benefit seniors as well.

Mr. SCULLY. I think the draft regulation that we put out last week has hundreds of pages of much more detail than were available before, and I would be happy to come up and go through it with you.

The CHAIRMAN. Thank you, Senator, very much. I appreciate it.

Senator Rockefeller?

Senator ROCKEFELLER. Good morning, Mr. Scully.

Mr. SCULLY. Good morning, Senator. How are you?

Senator ROCKEFELLER. I am well.

I want to know why it is that I am not smiling more broadly about the President's prescription drug plan. We had a lot of meetings last year, Bob Graham, John Breaux, and a number of us on

both sides of the aisle, and Max Baucus, obviously, Senator Grassley.

We went to various figures, but we had to deal with a premium, co-payment. It was at $53. People said, it will not fly. People had reminiscences of catastrophic health care, which was a great, great piece of legislation. It just got blown out because of misinformation and disinformation.

The President's plan is $190 billion. We have about 366,000 West Virginians who are eligible for Medicare. The way I calculate it, is that at 100 to 150 percent of poverty, those below poverty, below the 100 percent, 25 percent already receive Medicaid.

The total net, as far as I can figure, for West Virginia Medicare beneficiaries under the President's plan is 13,000 seniors. Thirteen thousand seniors. I want to know what is good about that.

Second, as you indicated, we have a discount program that averages around 17 percent. Yours, I believe, is closer to 8 percent, at least as GAO predicts it. I am trying to figure out where there is an advantage in that for West Virginia. We have a rather long history of it. The Golden Mountaineer discount card had a pre-prescription drug history of 20 years.

I am not smiling much about this. I understand the budget problems that Senator Conrad was talking about. But how is it that I go back to the people I represent and say, the President's plan got passed and 13,000 seniors will benefit?

Finally, it is very interesting to me, the chemistry and the dynamics of the way the steel Section 201 decision came about. There was a deadline. We cannot create a deadline on legislation like this.

But it forced all kinds of things to happen, decisions to be made, wrenching arguments within the White House and outside the White House to take place, and the decision was made.

In fact, I give the President good marks for making a decision which his predecessor declined to engage himself in. It does not save the steel industry, but at least we now know we have time to move forward.

I would like to smile more than I can about 13,000 seniors benefitting from the President's prescription drug plan, unless you have information which has just passed right by me.

Mr. SCULLY. Well, Senator, we have a pretty good track record of working on things together, so I hope we can work on this. I think the 13,000 seniors—and I do not know if that is the right number—would really be in the next 3 years that are the poor seniors in West Virginia.

Under almost every bill, they get nothing otherwise in the next 3 years. We are determined to help the poorest immediately. I hope the number is bigger than that. I would be happy to look at it with you.

As far as the West Virginia Mountaineer card, I actually read the whole thing last night. Surprisingly, your West Virginia Mountaineer card, which saves 17.5 percent, is virtually identical to the President's drug discount card.

In fact, under our MBRM, we could basically make the West Virginia Mountaineer card the Medicare West Virginia Mountaineer card. We believe that we would get 17 percent. The contractor that

runs that is Advance PCS, who runs it for the State of West Virginia.

It is designed virtually identically to our drug card. I believe that, through our advertising to 13,500 on the card now, I think if you had Medicare's endorsement, Medicare's marketing, and our 1–800 number, you would probably have 100,000 seniors with that card.

I think it would make the Mountaineer card much more effective and save money for a lot more people. I was surprised. I read it last night, about a 30-page document about it, and it is virtually identical to what we are trying to do.

Senator ROCKEFELLER. That should make me cheerful.

Mr. SCULLY. There is a little smile.

Senator ROCKEFELLER. It does not. But my time is about to run out. I am also very glad to see, incidentally, I think the generic drug thing is a huge part of this. I think we can save $100 to $200 billion if we do that properly, closing loopholes. They get 17 years to make profits.

The CHAIRMAN. Thank you, Senator.

Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. Thanks to the panel for being here. We appreciate, certainly, your interest and dedication to coming up with a solution for what we see is an unbelievable problem for our seniors in this country, and that is being able to afford the prescription drugs that they need and deserve, as well as affording the prescription drugs that we know are going to be an enormous part about being able to be cost-effective with health care in the future.

Certainly, as we look at Senator Conrad's charts and we realize that many of us are going to be in that area of hitting Medicare and Social Security in the coming years, we want to make sure that we have got something out there that is going to be able to hold down the cost of health care.

I just want to follow up on a couple of my colleagues' questions. First, a little bit about what Senator Snowe was talking about. In the low-income prescription drug proposal that you have in your plan, which is essentially kind of a Medicaid expansion with an enhanced matching rate, my concern—and I came in in the middle of your answer—is the number of the States that would actually be eligible there. You mentioned 35. I thought it was 18.

Mr. SCULLY. All of the States are eligible. There are only 18 that are already above 100 percent of poverty, so that they would not have to buy up to 100 percent. Every State is eligible.

Senator LINCOLN. Right. They are eligible.

Mr. SCULLY. It is just, some States do not cover up to 100 percent of poverty now, so not all of them would be a 90/10 match.

Senator LINCOLN. Without that FMAP increase that we really need, that would not happen, right?

Mr. SCULLY. No. They would all be eligible to. It is just as an incentive. For instance, Arkansas' match rate for the base program was about 70/30, roughly.

Senator LINCOLN. Yes. That is right.

Mr. SCULLY. So if you are below—and I was looking to see where Arkansas is. I think Arkansas is actually somewhere around 80

percent of poverty. The difference between 80 percent of poverty and 100 percent, is you would have to be funded at the regular Medicaid rate. Then you would get the enhanced match of 90/10 above that.

So from 100 to 150 percent of poverty, the Federal Government would pay 90 percent, but for the States that are below—there are about 18 that are above 100 percent of poverty now—every new dollar spent will be 90/10.

Senator LINCOLN. Right. But for those below, they would still have to make that difference.

Mr. SCULLY. Just for the difference, yes.

Senator LINCOLN. Right.

I guess one of my questions is, it seems very similar to really what was in the economic stimulus package to cover the displaced workers who were not eligible for COBRA.

I notice the administration was quite opposed to that. They were quite critical of the proposal and claimed that the States were not really in a position to take up that option. Has something changed? How is what we are doing here or what you are proposing in this different from what was in the Democratic stimulus package?

Mr. SCULLY. Senator, I hate to admit to you—and maybe Bobby knows—I am not familiar with it.

Mr. JINDAL. I think the one difference is, this is not intended to be a Medicaid expansion only. Rather, it is an option for the States to provide a low-income drug benefit.

One of the earlier answers Tom gave, is that this may be a way for some States to build something around the drug discount card in the same way that it would allow CMS to learn and build an infrastructure for private delivery. The hope would be that States would also have that opportunity to use private delivery mechanisms to deliver this benefit, if I understand it.

Mr. SCULLY. I think it is two things. One, you do not have to use Medicaid. The States can use any mechanism they want. West Virginia could use its Mountaineer card, Iowa has a card. You can use a private mechanism, a public mechanism. You identify delivery mechanism to those people, and we will fund 90/10. It does not have to be Medicaid.

I think your question was more that you had a matching funding for displaced workers, but that was also for an entire insurance package. This is just for a much more narrow benefit, a Medicare drug benefit. It is obviously for very poor people.

I think there is an honest disagreement about it about dislocated workers in COBRA. The common denominator is obviously the State matching rates and where they come up with it. I think we thought 90/10 is as enhanced a match as has ever been done.

Senator LINCOLN. Well, following up on another question, when you talk about the discount drug card program that you have proposed, what is the guarantee for those savings? Particularly, what is the guarantee to the rural pharmacists that were mentioned earlier that provide a real health care need in rural America?

Mr. SCULLY. Well, it is a voluntary card. But we also require, if you are going to participate—let us say you are Express Scripts or just pick anyone, say, Walgren's, or a couple of the different pharmacy companies actually applied.

If you want to put together a network, you have to show that you have a broad, diverse network. So I believe that rural pharmacies, particularly in towns where there is only one, would be likely to be in.

I also think that the way it would probably benefit rural areas—and this is not a benefit. It is, obviously, we think, an important step but it is not going to solve all of our drug problems. But if you are out in rural Arkansas, you are probably not getting any particular bulk negotiating benefit.

If the rural pharmacy and the seniors were signing up through Express Scripts, or Well Point, or one of the other companies that has shown an interest, or a Walgren's, or whatever card, they are likely to get the benefit of some bulk discounts that they would not get normally in a rural area. They are going to be tied into a bigger purchasing network.

Senator LINCOLN. Likely. But still, in terms of——

Mr. SCULLY. But it is a totally voluntary system, so it is certainly possible that pharmacists are not going to want to participate, and seniors are not going to want to participate.

Senator LINCOLN. Thank you.

The CHAIRMAN. Thank you very much, Senator.

Thank you both for appearing today. I just want to remind everyone here today that we have an enormous challenge. First of all it is on policy, second on politics. On policy, it is just fitting these pieces together: long-term, health of the Medicare hospital insurance trust fund; short-term, getting some benefits to people who desperately need them, cutting costs but giving people the ability to pay for and have prescription drug benefits.

I just might say, in my home State of Montana, 30 percent of seniors have no coverage whatsoever, no prescription drug coverage, none whatsoever. They pay the highest drug prices of anyone else in the world, higher than other parts of America. We need help.

So, first, we have an enormous policy challenge in fitting these pieces together. The other, is political. People in this town, as we all know, tend to dig their heels in, with pride of authorship and so forth.

I just urge all of us in this room, all of us who care deeply about this subject—and I know we all do—to go the extra mile to get the facts, avoid the rhetoric. Let us find out what works, what does not work, then work together to get a part of this done step-by-step.

Rome was not built in a day, but still Rome was built. We have got to go the extra mile if, in this political season, we are going to get something passed here that makes some sense.

It is an extremely difficult challenge we face, and I just urge all of us to go the extra mile because we are here to serve people. It sounds kind of corny, kind of trite, but it is true. Sometimes I think too many people in this town forget that, so let us just remember that and get this thing solved.

Mr. SCULLY. I could not agree more. Thank you, Mr. Chairman.

Mr. JINDAL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. All right.

The next panel includes Hon. Dan Crippen, Director of CBO, and also Hon. Bob Kerrey, president of the New School University, representing the Concord Coalition.

The question is, Senator Kerrey, why is your name plate so much larger than that of Dr. Crippen? The answer, we have concluded, is because you brought your own. [Laughter.]

Dr. CRIPPEN. He has been elected to something, I have not.

The CHAIRMAN. Well, I am going to have you go first, Senator.

STATEMENT OF HON. BOB KERREY, PRESIDENT, NEW SCHOOL UNIVERSITY, REPRESENTING THE CONCORD COALITION, NEW YORK, NY

Mr. KERREY. Thank you, Mr. Chairman, Senator Grassley, members of the committee. I am going to begin by thanking you for the opportunity to come down and testify.

Let me begin by offering my sympathy on this particular issue, because it seems to me, in a lot of ways, the one thing that has not changed in the year that I have been gone is that people very often ask for contradictory things.

Mr. Chairman, if you do not mind, I would just ask that the entire statement I have prepared be inserted in the record.

The CHAIRMAN. It will be included.

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

Mr. KERREY. People want lower taxes, higher spending, they want to cut wasteful programs but not my military base, not my particular program, et cetera. That is a constant in a representative democracy.

It is exceptionally difficult here because you have got a vital underlying service, health care, and a life or death issue having to do with people whose health status has deteriorated. They are dependent upon others to help them in their lives. As a consequence, they are enormously vulnerable.

John Rather said hello to me back here, with AARP. I showed him a picture of my six-month-old son Henry, who will be graduating from college in 2022. So, I celebrate the idea that we are all living longer, because I will have to live a great deal longer than my parents did in order to be able to just see him graduate from college.

John said, well, perhaps we ought to be thinking, in AARP, of adding a child care provision to Medicare. [Laughter.] That would certainly be helpful for me.

Mr. Chairman, you have invited me to come down here to talk about adding a prescription drug benefit to Medicare. My simple advice, is do not do it unless you are prepared to make structural reforms in the Medicare program itself, or better, to overhaul the entire way we finance health care in the United States.

I believe that adding a prescription drug benefit to Medicare without fundamental reform will partially solve one problem, while increasing the problems we have in several other areas.

It will unquestionably help solve the problem of current Medicare beneficiaries who are struggling to figure out a way to pay for their prescription bills, but it will also increase the problem of declining shares of our Federal budget available for spending on such things as education, child care, transportation, and technology.

At best, Mr. Chairman, it does nothing to solve—and worse, it increases—the problem faced by non-Medicare eligible uninsured working Americans.

With budget caps gone, income taxes already cut, and bipartisan enthusiasm to spend considerably more on defense, I do think it is safe to say that the brief and shining era of fiscal surpluses is over.

Last year's Congressional budget resolution set aside $300 billion over 10 years for a Medicare prescription drug benefit. Last year, all things seemed possible. But last year, CBO was projecting a 10-year unified surplus of $5.6 trillion.

We just heard from Senator Conrad showing there has been a $5 trillion negative swing in the non-Social Security surpluses, going from approximately, I guess your numbers were, a $2.7 trillion surplus over the next 10 years to $2.3 trillion deficits over the next 10 years, just in a single year.

This year, Mr. Chairman, I just think you can reach any other conclusion, that even a $300 billion proposal is going to have to be financed by borrowing from the public or from Social Security surpluses.

The assumption there that there are going to be Social Security surpluses is dubious if two of the following three things are true: one, that most of last year's tax cuts, along with several other popular provisions, will be extended rather than repealed by 2010, or that Congress will not do something about this growing problem of individuals having to pay an Alternative Minimum Tax, right now about 3 million people, going to 40. It is likely Congress is going to have to take action to deal with that problem, which will also cut revenue out of the current projected stream.

Or that the defense and non-defense discretionary spending are not going to grow any faster than inflation. I mean, I think these are presumptions that are built into the current baseline that are not likely to be very realistic.

The Concord Coalition, of which I am currently co-chairman, prepared an alternative baseline using CBO numbers showing what would happen if just two of these things occur. The two that we picked were all expiring tax cuts are extended and discretionary spending just keeps pace with GDP growth.

It is far from a doomsday scenario and does not plug in lots of other alternatives that will probably happen. It seems a lot more plausible, Mr. Chairman, than the official baseline.

Under these modest assumptions, the entire unified surplus is virtually eliminated. Stated more directly, the payroll taxes, in excess of costs of Social Security and Medicare that are now being used to pay down debt, will be needed to pay for defense and non-defense spending.

The bottom line is, there just is not any room to add a major expansion, a horizontal expansion, such as a Medicare prescription drug benefit. In addition, and I want to emphasize, as worthy as it absolutely is, in isolation to all other problems, would significantly impair the financial future of working men and women, the people who pay the bills, and their financial future has already deteriorated significantly in the last year.

Consider just these things. Last year, Americans are looking at a future in which we were projected to eliminate the public debt

held by the people of the United States by 2008. Total debt limits were not expected to be exceeded until 2009. Net interest payments over the period from 2002 to 2011 are estimated to be $622 billion.

Well, today we no longer forecast that public debt will be eliminated. The debt ceiling may be reached this month. Net interest payments over the next 10 years are going to be $1 trillion more than was previously projected.

Mr. Chairman, that is $10,000 per American household over the next 10 years. That is $1,000 per year. That is the change that has occurred in a single year in the financial future that Americans households have.

What makes this gloomy picture of our financial future worse, is that, as Senator Conrad pointed out, we still have not changed the Federal laws to accommodate for the baby boom generation.

From 2006 to 2026, the number of workers whose taxes support retirement benefits will increase from $166 million to $174 million, and that is while the number of Social Security and Medicare beneficiaries will increase from 48 to 78 million.

Instead of being able to tax three people to pay for benefits, we will be taking two people to pay for benefits. The details of what will happen were presented to Congress, Mr. Chairman and members of the committee. You have seen the evidence from the General Accounting Office in February.

I regret, and I sincerely regret, that most of us outside of Congress, outside of Washington, DC, were not paying much attention to what GAO was saying and we are still suffering the illusion that Medicare's future is still quite bright.

We have been focused on the improvement of the HI trust funds, a shorter range solvency status, and we missed that Medicare's long-term outlook has worsened significantly during the past year.

I will isolate three conclusions. Actually, I do not think I will, in the interest of time. It is in my statement. You all know what GAO has said. I do not need to repeat them to you.

It was a very sobering wake-up call, I think, for all Americans as we try to figure out how to solve this problem, as you, Mr. Chairman, quite eloquently said a few minutes ago.

All of this said, I know that there is tremendous pressure on you from 35 million elderly Medicare beneficiaries, 5 million disabled, and all of their families. It is not just an issue of the beneficiaries themselves. Their families, too, are worried about, how are we going to be able to help our moms and dads to be able to pay for these prescription drug costs?

I know that they are telling you that they need help to lessen the burden of paying for their pharmaceuticals, and I know you have been moved by the stories of individuals who simply do not know where they are going to get the money to pay for a life-saving prescription ordered by their doctor. I know that few things affect us personally more directly than health care.

Still, Mr. Chairman, I urge caution. Medicare is social insurance with an asterisk. The asterisk informs us that the program is, for several reasons, not straight insurance.

First of all, it is not fully funded. The current unfunded liability for future Medicare beneficiaries is $10 trillion before a prescription drug benefit is added. Second, it is not true insurance because

the insurer is underwriting a risk that is almost certainly to be used continually. This is especially true with most of the prescription drug proposals where the usage will be expected and annual.

I also urge caution, Mr. Chairman, because money is money. By that, I mean the distinction between government money and private money is largely an ideological distinction and not a real one.

While it can be very much true that government spending, that is to say Federal tax spending, can grow the private sector, and all you have to do is look at the impact of Federal spending on most rural counties in the United States to understand the impact on the economy, the sale of goods and services in the private sector generates the revenue taxed by the government for its services. It is a basic, fundamental observation, but it is important to make it.

In the context of what is happening to the Federal budget, it is not academic. Too many citizens right now answer the question, where are we going to get the money for a prescription drug, well, the government is going to pay for it.

Well, current beneficiaries need to understand most of the money for this benefit will not come from them. Most of the money will come from a tax on the wages and salaries of Americans who are in the workforce.

A growing number of these workers, Mr. Chairman, who are seeing an increasing share of their income going to insure someone else, do not have health insurance themselves.

These workers are also the ones who suffer the negative consequences of having too little to spend on education, on child care, on transportation, and technology.

Current beneficiaries also need to understand that there is a limit to Federal spending. Since the second World War, the Federal Government has rarely removed more than 20 percent of the U.S. economy for taxes. Federal spending since the second World War has never gotten above the 23.5 percent of GDP it reached in 1983.

For the most part, it has hovered around 20 percent. This 20 percent number has remained relatively constant and was trending downward during the 1990's economic expansion.

What has not remained constant, is the mix of Federal spending within that 20 percent. While spending on health and other entitlements has risen, spending on defense and non-defense appropriations has taken up a declining share of the budget and the economy and the trend is forecast to continue.

Mr. Chairman and members of the committee, it again connects back to this problem that we are going to have a little more than 20 years from now, when we are only going to be able to tax two workers per retiree if we continue this under-investment. It seems to me it is going to be relatively difficult for us to keep tax rates at a reasonable level in order to support future beneficiaries.

When the baby boom generation begins to retire in six years, Medicare spending will increase rapidly as a percent of our Federal budget. Mr. Chairman, that is also in the GAO report. I do not need to run through that as well. I am trying to cut this thing down to size. I see that I am over-staying my welcome.

Dr. Crippen over here, even though his letters are a lot smaller than mine, is a current Honorable, not a former Honorable, so I am going to get out of the way.

Mr. Chairman and members of the committee, I would like to propose something for you to consider. Oftentimes in life, intuition is a pretty good guide. It tells you maybe you ought to do something. But sometimes it is not.

I am suggesting, in this particular case, intuition is not a very good guide. Intuition right now tells us, as you look at the numbers, somehow you have got to put future restraint on the cost of the entitlement programs. I would urge you to think about the possibility that the counter-intuitive solution is the best one, which is to expand in a horizontal way the entitlement program.

By horizontal, I mean change the current Federal law. Under current Federal law, here is the way you become eligible to have somebody else's taxes pay for your health care.

Under Federal law, if you have worked for 40 quarters and you are 65 years of age, you are eligible for Medicare. If you are disabled under Medicare, you can also get coverage there, and you have to demonstrate that disability. You can get it as I was, you can get blown up in a war and you are eligible for a subsidy. Somebody else's taxes are being used to pay for your health care.

You can prove you are poor and promise to stay poor, and we will provide you with tax revenue from somebody else to pay for your health care.

You can join the military service, you can work for the Federal Government, you can find a job with an employer who uses the Tax Code to reduce the cost of purchasing insurance, although even there there is this perverse fact under Federal law that says the higher your income the higher your subsidy, the lower your income the lower your subsidy. Indeed, if you do not pay any income tax, you are not going to get any subsidy at all. If all you are paying is payroll tax, there is no subsidy for you.

The last is, under Federal law, if you have got a kidney that needs dialysis—at least we have got one organ covered—you do not have to prove anything under the Renal Dialysis program.

In other words, under current law, only people who are not eligible, who can prove one of these categories, are eligible. That leaves 40 million people who are not, who simply are not old enough, they are not disabled enough, they are not poor enough, they are not lucky enough to qualify.

On the other hand, every single one of these people who are in the workforce are eligible to have their taxes withheld to go for somebody else. That is the way it is working. They have a mandate on them already, that the taxes be collected to pay for mine, to pay for yours, and everybody else that is eligible under one of these other programs.

So I would strongly urge you to step back just a little bit, if it is possible. I know it is very difficult to do, because it means threatening, in some cases, preexisting programs.

But to simply say, under Federal law, you are eligible if you can prove you are an American or legal resident, you put all 280 million of us in the same group.

And then let us have a debate about how we are going to finance it. It does not have to be socialized medicine. It does not have to mean higher spending. It does not have to be any of the things that oftentimes people use as a fear tactic when they are trying to get

us to do the right thing. It does not have to be any of that. It could be 100 percent market, it can be 100 percent government.

But, for the first time, we will have a United States health care system rather than a system that forces people to organize themselves into various groups as a consequence of meeting one of these previous categories that, under Federal law, permits them to be subsidized.

Mr. Chairman, no doubt this proposal seems a little out of place, given that you are talking about a prescription drug benefit. But you asked me, and you knew me before, and you knew that I sometimes say things that are out of place. So, I guess you have yourself to blame for that. [Laughter.]

I do want to emphasize something I tried to at the first. Oftentimes in the deliberation, especially about the growth of entitlement spending over the future, the requirements of mandatory spending, we leave the impression that longer life expectancy is somehow bad news, and it is not.

As a consequence of advances in medicine, as a consequence of individuals changing their behavior, recognizing various health risks, people are getting older and they are enjoying their lives an awful lot more in no small measure because of Medicare and of Social Security.

So, I do hope, on behalf of myself who hopes to be at my son's graduation in 2022, I do quite expect that you all will have the collective wisdom necessary to figure out how to make certain that these programs are there so as to sustain all of us. Again, not just current beneficiaries, but future beneficiaries as well as we try to figure out how to live healthier and longer lives.

Thank you very much.

The CHAIRMAN. Well, thank you very much, Senator, for that excellent statement. It is provocative, insightful, intuitive, logical.

Mr. KERREY. And a little too long.

The CHAIRMAN. And very, very helpful and interesting.

Dr. Crippen?

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

Dr. CRIPPEN. And, as always, a very tough act to follow.

Mr. Chairman, Senator Grassley, members of the committee, you have asked us here today to share with you the results of our analysis of the President's budget as well as the development of this year's baseline for pharmaceutical spending by the elderly.

A general caution is in order on what I am about to say. We have not had time to rigorously test our drug modeling in the light of new evidence since last fall, when we last went through the exercise. We will do so next week and hope to be able to update our analysis of existing proposals by the end of this month.

But, as always, our estimates of the increase in drug spending in the next decade cannot be applied to estimates of prior legislative proposals. Most will be more expensive than we thought last year, but not uniformly so.

As you can see from the first chart, Mr. Chairman, the Congressional Budget Office (CBO) estimates that under current laws and regulations, mandatory spending for Medicare will total $223 bil-

lion in 2002 and $3.2 trillion over the next 10 years, growing at an average annual rate of 7 percent in 2002 and 6.6 percent over the 10-year period (see the third chart).

CBO's estimate of Medicare spending over the next decade, as Senator Grassley noted earlier this morning, is $225 billion greater than that of the Office of Management and Budget (OMB). There are at least three differences between us that are worth noting, but I do not want to overstate them.

First, we expect that the new payment systems that are going into place for home health and skilled nursing will not bring down the case mix or the cost for more expensive recipients as quickly as OMB anticipates.

Second, we expect more beneficiaries to take advantage of those services than OMB does. Third, we project a more dramatic reduction in Medicare+Choice enrollment, which we think will fall from 14 percent today to something like 8 percent of enrollees by 2012.

The President, as Mr. Scully just testified, has proposed changes to Medicare that include two major components; one of which is a Medicare-funded program that gives States the option to expand prescription drug coverage. I will not go into the details of that proposal; you just heard all of that.

We estimate that the President's Medicare proposals would increase spending by less than $2 billion in 2003 and by about $170 billion over the 10-year period. In contrast, the administration estimates that those provisions would increase spending by $190 billion over 10 years. Nearly all of the difference between the two numbers lies in estimates of the cost of offering coverage for prescription drugs to low-income Medicare beneficiaries. As has already been noted here, I think by Senator Snowe, our assumed participation rates are somewhat lower than OMB's assumed participation rates.

Last year, Mr. Chairman, we estimated that spending by Medicare enrollees for outpatient prescription drugs not otherwise covered by Medicare would total about $1.5 trillion between 2002 and 2011. This year, CBO's preliminary projection for that same time period is about $1.6 trillion, or something like 8 percent higher.

However, our estimate of spending for prescription drugs over the current 2003–2012 projection period for this budget is roughly $1.8 trillion, or 21 percent higher than last year's projection.

Nearly two-thirds of that 21 percent increase simply reflects the shift in the projection window, which effectively substitutes a high-cost year, 2012, for a relatively low-cost one, namely, 2002.

We have a chart before you that attempts to illustrate that phenomenon (see the fifth chart). As you see, you pick up 1 year on the upper end of this curve and lose a year on the lower end.

In 2003, our projections suggest that, on average, a Medicare beneficiary will incur more than $2,400 in expenses for prescription drugs used on an outpatient basis.

The median value for those expenses, which means the point at which 50 percent of recipients are below and 50 percent are above the level and which is probably a more representative measure of what most people spend, will be nearly $1,500 per person that year.

We do need to keep in mind, however, that there are roughly 4 million beneficiaries who will incur no drug expenses this year, and another 8 million, for a total of 12 million, who will spend less than $500 this year.

Even without a Medicare prescription drug benefit, CBO expects average spending for prescription drugs to grow at a very rapid pace—an average annual rate of about 10 percent per beneficiary over the 10-year period.

That rate is, frankly, significantly lower than recent rates of growth—and there are some reasons for that—but it is still very high. Our analysis of Medicare's Current Beneficiary Survey suggests that in 1999, one-quarter of the Medicare population had no prescription drug coverage and 75 percent had coverage for at least part of the year. We have a pie chart—I think you have a copy in front of you, so you can see it better than the board (see the seventh chart).

We should note, though, that even those folks without insurance filled about 19 prescriptions that year compared with 30 for the elderly with insurance. That is certainly not meant to diminish the problem. The uninsured, filling two-thirds as many prescriptions, may be forgoing needed medication and may be filling those prescriptions at very large personal sacrifice.

On average, the share of the drug expenditures of Medicare beneficiaries paid directly out of pocket in 1999 was about 40 percent, which is the same share paid out of pocket by the U.S. population as a whole. Thirty percent of Medicare beneficiaries obtained coverage for prescription drugs through employer-sponsored retiree benefits; 16 percent obtained it through Medicaid; and 11 percent had drug coverage through individually purchased medigap policies.

Mr. Chairman, to repeat the primary piece of new analysis we present today, CBO estimates that outpatient prescription drugs for the Medicare population will total $1.8 trillion between 2003 and 2012, even before any Medicare benefit—a benefit that could increase both demand and prices and add to that already very large number. Anything short of a very targeted benefit will bring to the Federal budget significant costs that are now being covered by others and may also increase the total costs faced by many of the beneficiaries who are now insured.

Before I conclude, I want to do as Senator Kerrey did. I want to put these many numbers into a more complete context. This chart, which I have dragged around with me to virtually every hearing I have been to in the last couple of years, shows what the contribution of the working population will be to those who are retired over the next time period, through 2030 (see the second chart).

As Senator Kerrey said, when the baby boomers retire, that trend is inexorably up. Spending for the "big three' entitlement programs will more than double from their current figure of roughly 7 percent of gross domestic product (GDP) to well over 14 percent—to 15 or 16 percent.

The implications of that increase are manifold, but one, at least, is that for revenues, as Senator Kerrey also said. Since World War II, we have collected, on average, Federal tax revenues equaling

about 18 percent of GDP, and in some years we have spent more than that and in some, less.

But in order to accommodate the change posed by the baby boomers' aging in the demands on the Federal budget, one would envision either having to raise taxes to almost 30 percent of GDP; as the extreme case, having to eliminate the rest of the Federal Government as we now know it; or having to borrow the equivalent of 10 percent of GDP year after year, which is probably not sustainable for a very long period.

So the change in fiscal policy, or in the outlook for fiscal policy, is quite dramatic. We have seen from the past—in fact, since Social Security was instituted—that there are very few years in which spending for the Medicare program per capita (per beneficiary, that is) did not grow faster than the economy.

So it is likely that this doubling of GDP is a conservative estimate. At the same time, we cannot anticipate that we are going to be dramatically reducing Medicare spending, at least not under current law.

Even if we were to hold growth of per capita Medicare spending to the growth of the economy—something that has been rarely achieved, as you see by this last chart—we would obviously still double the amount of budgetary resources going to Medicare benefits for retirees. It has rarely been the case that, as I said, the growth rate of Medicare spending did not exceed the rate of economic growth.

It is in this context, Mr. Chairman, that I urge the committee, much as my colleague on the panel did, to consider changes to Medicare. Certainly, anything that adds to the cost of these programs, from increases to provider payments to additional pharmaceutical benefits, will only exacerbate this outlook. What may seem affordable today for us to provide for our parents may not be as easily financed by our children for us.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Crippen.

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

The CHAIRMAN. Senator Kerrey, you have served in this body, you have served in your State as Governor, you are president of the university. You have quite a bit of experience in public policy.

What are your thoughts on how we begin to put some of these pieces together? I mean, you have talked about the tough choices that we have. It is clear that we do have tough choices. There are also needs. You were very involved in the Medicare Commission recommendations.

What are your thoughts on how we look, from a policy perspective and from a political perspective, and begin to take some of this on? That is, get some solid progress, but in a way that recognizes both the need for fiscal discipline and also the need that a lot of seniors have for benefits.

Mr. KERREY. Well, Mr. Chairman, that is a heck of a question.

The CHAIRMAN. Just thoughts that go through your mind.

Mr. KERREY. Well, let me make a couple of observations. First of all, a lot of what you have already done has produced results. I know Senator Conrad just left, but I know you, Senator Baucus,

and my guess is Senator Snowe as well, as border States, that you have been talking for years about the high cost of pharmaceuticals. Well, that talk has produced results.

The CHAIRMAN. Yes.

Mr. KERREY. I mean, Eli Lilly, Pfizer, and a couple of other companies, I was reading in the newspaper yesterday, are going to offer deep discounts—deep discounts—to low-income seniors. Bristol-Meyers Squibb responded to concerns that all of you were expressing, the high cost of providing AIDS drugs in sub-Saharan Africa. There are examples of things that you have already done that have produced some results.

I do not think it is small. I think it is very important, both for you to make that observation and for the American people to give you credit for having gotten that done. I heard Mr. Scully talking about it earlier. Oftentimes there is an observation of, gee, we have been working on this for 20 years and nothing has happened. That just is not true.

There has been a lot of substantial improvement, expansion, and progress that is being made. So, I would begin with that. Otherwise, I think it is very difficult to get the kind of support that is necessary.

Second, you need some kind of process. God help me if the word "commission" comes out of my mouth, because I would never recommend that to all of you. But you do need some sort of process that allows you to accommodate a really hard truth, which is, it is a lot easier to give something to somebody than it is to take it away.

I remember the big debate in 1997, as we were trying to figure out how to balance the budget. I was down here with the witnesses and listened to every single witness say, take it from him. I want more. It is the other guy that is the problem. It sort of went around the circle. I think you need some process to get that done.

Under the proposal that I made, which is sort of an outline, somebody has got to give something. I will use myself as an example.

In 1969, when I came home from the war, I needed help and the taxpayers gave it to me. They shared a little of their income and paid for my prostheses. I had surgery for the next 10 years, until I was able to sort of walk and do things normally again. Well, I went to a government hospital. It was socialized medicine. It actually worked pretty good. But I do not need it today.

But when I go to a prosthetist in Brooklyn, New York now, as I am doing actually right now, the taxpayers are picking up the bill.

Well, all right. All in favor of giving that up, say aye. It is a pretty small number. In theory we are sort of willing to do it, but in practice it gets difficult.

So you need, Mr. Chairman, some sort of process that allows, in a bipartisan way, the evaluation of who is going to give something up because otherwise you cannot get there.

With health care, lastly, it is just undeniably true that our appetite greatly exceeds what is reasonable. I mean, I want to live forever and I want somebody else to pay for it.

My idea of affordable, is I get the absolute best doctor, best hospital in the world, and I pay as little as possible for it. It is unreasonable. When I say "I," I mean me, personally. I have said, gee, I am asking for too much and I pull it back in. But with health care, the demand oftentimes just exceeds what is reasonable.

I would urge you to, (a) take credit for things you have already done and let the American people know that progress is being made through your work and through the laws of the Congress; and (b) I would also urge you to look for some process that allows consideration of something that might be the right solution, though it might require that somebody give something up. This, I know very well.

I do know that American election has been reduced down to 6 to 8 percent of undecided voters. We call them uninformed. They are going to vote. We know with 100 percent certainty they are going to vote.

When we call them uninformed, that is being kind. You have to be kind. I call them monstrously ignorant. They have not been able to figure out what is going on, and they are going to vote and they are going to make their decision based on the last 30-second ad they see.

If they see a 30-second ad that says, Senator Kerrey voted against veterans benefits because he voted to put an income test on veterans programs, they can turn every veteran and they are likely to go out there and vote against me.

So, I am very much aware of the risks that you all take when you try to do the right thing, especially it means, in a responsible way, saying you have got to do something responsible out there yourself if you could ask for something.

The CHAIRMAN. Thank you so much.

Senator Grassley?

Senator GRASSLEY. Well, I thank all of you very much for your hard work in putting this testimony together. I only have two questions. The first one, I would like to ask both of you to comment on, and on the second one, Director Crippen.

Those who advocate a drug benefit of, say, around $750 billion—that is a figure we have heard today—it seems to me that they are advocating spending the entire Medicare trust fund on a wholly new benefit.

Given that the trust fund is supposed to secure current Medicare benefits for today's and tomorrow's retirees, do you see risks in such an approach, and if so, what are they?

Senator Kerrey?

Mr. KERREY. First of all, I understand the proposal. I understand why it is being made. It is basically saying, this is what the need is. I found in my years with AARP, who have made this particular proposal, though I have disagreed with them from time to time, they are responsible.

In all of the debates that I have had with them, they are willing to accommodate the need for people to pay a responsible share of the bill. So, I have not found them to be irresponsible. They are pricing it, I think, at what the demand is, what the real need is likely to be.

The problem is, in my observation, we cannot afford it. You cannot afford, especially, to do it without both structurally reforming Medicare and structurally reforming the entire health care program, otherwise you are going to convert the Federal Government in 30 years to an ATM machine. You are going to just have money transferred in and transferred out. That is all you have got left.

If you have got only two workers to tax in 2028 per beneficiary and you are under-investing in their education, their training, their technology, transportation, all of the things that make them more productive and lift their earning power and standard of living, if you are under-investing in that over the next 20 to 30 years, as Dr. Crippen said, the tax on the people that are left is going to have to be so high that nobody is going to be willing to support it and they are going to be left with, I think, substantial cuts out there in the future that are going to be necessary as a consequence of, as Senator Conrad said, disregarding the looming problem that is sitting there so obviously for us to see.

Senator GRASSLEY. Dan?

Dr. CRIPPEN. Senator, as a matter of economics, if you will, and not policy or politics, it really does not matter how you account for the funding of these benefits—whether they come from a Medicare trust fund, a Social Security trust fund, or borrowing from the public. That last option has some consequences, but the financing of benefits is still less important than the level of what a given proposal will add to both current and future spending for the elderly.

So, as an economist, it is of less concern to me exactly which trust fund provides the money or how you account for what you spend. Let me say—again as an economist—that under many of these proposals, somebody will end up paying.

Providing relief for beneficiaries out-of-pocket spending is difficult to do without federal funds displacing existing coverage and moving current spending by beneficiaries under the Federal budget. Even the drug discount card mechanism have problems—obviously, the more people who get discounts, the more discounts will look like retail.

Then you can decide who is paying, whether it is higher prices for some group than for another, or lower prices for the pharmaceutical companies. But, ultimately, the bill will be paid if there is a demand for and utilization of the benefit.

So, again, as an economic matter, the trust fund construct—ascribing revenues and spending to a specific fund—is not important in a macroeconomic sense.

Mr. KERREY. I would add, Senator, let us say a group of you got together and proposed to take a point and a half of GDP, which is about what this is, per year and put it into real productive investments in measurable improvement in child care, increasing the percentage of our kids that are going to college, transportation technology, things that are arguably going to produce and increase the capacity of those future earners to be able to support retirement programs.

Even though the current fiscal situation looks rather gloomy, I am a lot more interested in that. I am a lot more likely to sort of bend my fiscal ideology a little bit to accommodate the need to

make those kinds of investments which I think are urgently needed today.

Senator GRASSLEY. In your remarks, Dr. Crippen, you surely projected very high costs for drugs. I do not have any reason to believe that that is not a reasonable projection.

It also certainly demands that we proceed with caution. You make the point that the cost of any drug benefit will depend greatly on the cost management tools. These clearly have a major effect on your estimate of the potential cost of drug benefits to the government.

In particular, how critical is it that there be competition among risk-bearing private sector entities in order to control costs?

Dr. CRIPPEN. In our view, competition will potentially help a great deal in holding down not only the initial level of a drug benefit but also the increases over time. Again, it will depend largely on how many competitors are involved and what they can do.

For example, the proposal that President Clinton made before he left office had some private competition pieces to it. But one thing that it proposed was that any doctor could override any formulary that a private pharmacy manager or others might have imposed.

Now, that may be the right thing to do from a health care point of view, but that kind of loose control would mean, of course, that much smaller savings could be had from the normal things that a pharmacy benefit manager would do.

So, there are two pieces to controlling costs. You need more than one provider in order to have competition, but you also need to allow providers to use the kind of tools they do in the private sector to get many savings overall.

Senator GRASSLEY. All right.

Senator Baucus stepped out. So, Senator Breaux?

Senator BREAUX. Thank you very much, Mr. Acting Chairman. Thank you.

I thank both of you. Bob, thank you very much. I mean, you work with the Concord Coalition in addition to serving as the president of the university. It keeps you in public policy, and we thank you very much for taking time to come down and visit with us, and for your frank and candid recommendations.

As always, Dr. Crippen, thank you for a very detailed and very alarming, at the same time, report to the Congress.

I have just got one question for both of you to comment on, if you can. AARP is going to be on the panel next after you and they are going to recommend $750 billion for a prescription drug program that should be paid for by taking it out of future Social Security surpluses.

They are going to tell us that it is irresponsible to somehow pay for any kind of increases in funding for home health care, for nursing homes, for doctors, for hospitals, for rural hospitals until they get the $750 billion prescription drug package.

Can you give me a comment on what you think about that recommendation, Senator Kerrey?

Mr. KERREY. Well, I would urge you to vote against it, and to be sympathetic. My earlier math was incorrect, by the way. Seven hundred and fifty billion dollars is a huge amount of money, but in the United States it is about 7/10ths of a point of GDP.

That GDP figure is much more likely to respond in a favorable fashion, in my view, if you all are sitting there saying, how do we invest in our people so they have the capacity to produce the income necessary to tax in order to produce these benefits?

I do not see how you can fit that $750 billion foot into the shoe that is being provided to you with the numbers that Dr. Crippen showed, that Mr. Walker showed to the GAO.

It just is not there, unless you are willing to push Federal spending way beyond the 20 percent figure and allow the deficits to go even larger than they are and increase the debt far beyond what we currently have.

But worse, Senator, the problem that I see is that it is mandatory, it is in law, you do not vote on it. Once it is in law, it is done. It is done every single year. To take it away or reduce it in the future is exceptionally difficult to do. What it will do, is it will squeeze out our capacity to make those investments in our children.

I do not think AARP is, again, an irresponsible group. They understand the intergenerational importance of this program. But if that were to be enacted, I think it would threaten the intergenerational support that both Social Security and Medicare currently have.

Senator BREAUX. Thank you.

Dr. Crippen, can you comment on the concept of, what is it going to do to the future of the Social Security if we just take that much out when the conditions of the country are as they are?

Dr. CRIPPEN. As I said to Senator Grassley, Senator, I am less concerned about where you account for the dollars, where they flow from or to, than I am about the totality of what we are doing or committing ourselves to in the future.

In some sense, you and I are now paying a little more than we need to for our parents' benefits; hence, we have a little surplus in those accounts. So we could afford to perhaps buy them a pharmaceutical benefit of some magnitude.

But that begs the whole question of, what are we going to fund elsewhere, potentially, in the Federal Government? And in the future, how are our kids going to pay for it?

As Senator Kerrey said, the larger the economy, the easier it will be for them. But we are still doing things here that will add greatly to their burden when you and I are retired and asking them to foot the bill.

One other thing I would simply say, in addition to endorsing most of what the Senator said, my colleague on the panel here: incentives do matter. So, one has to think about how you structure a prescription drug benefit.

As you and others have said, you need to think about pharmaceutical benefits in a larger context, not just as an addition to the existing program.

So to try and impose political limits—to say we need to do this first and something else second—while understandable, is probably a mistake for the survivability of the program.

Senator BREAUX. Thank you.

Senator ROCKEFELLER. Senator Kerrey, I thought you raised some interesting points. If you look at the administration's pre-

scription drug plan, it sort of takes me back to the Commission. And I agree with you. There has been a tremendous amount that has been done in the last 20 years on health care. An enormous amount. People forget about it. Very people know about it when it does happen. But it has happened and we know it.

If you try, basically the administration's prescription drug program has a minimal effect and is not defined as to what is going to happen. Does it include catastrophic? What benefits happen? It is not there. It covers a very small number of people.

I would posit, without knowing at all, that they may have picked the low income in order to keep the numbers small, because I am not sure that the low income is where they would have gone first, the administration, that is. I do not know that, but I would just put that out there for the moment.

So you get into a situation where everything checkmates everything else. As has been pointed out, somebody has something they do not want to give up so nothing moves, or you have got VBA and 80 percent of the hospitals in West Virginia, skilled nursing facilities, home health that are losing money.

West Virginia cannot do that very long and stay open, so hospitals close. That affects everybody. It affects seniors, affects all West Virginians. And to the extent that it is true in other States, which it is in many cases, it affects all Americans.

So this business of sort of choosing, as you say, Dan Crippen, it gets to be very difficult. So I am going to have an intuition and see how you react to it, Senator Kerrey, President Kerrey.

My guess would be, at the rate that we are going now in Congress, the way the discussions are going, the way the hearings are being held, the way Democrats, Republicans, conservatives, liberals, moderates go at each other, we will stalemate once again this year.

It will be like the stimulus package. It will be like prescription drugs last year. It will be endless discussions, endless meetings, and there will be no prescription drug at the end of this year.

Then we will say, well, we will do it next year. It could be a different year. Yes, it could be a much worse year, too. We could have a series of terrorist acts that would cause us to spend a lot more money on things like aviation security, in which we created the second-largest agency since the end of the second World War just to do screenings.

So what happens if you say, look, we have got terrific budget deficits that have suddenly come, and as Kent said, we have got nothing but red ink for years and years. I think his chart ran out in 2012. Years, and years, and years of red ink. All right. So we have got those budget deficits.

But, as you indicate, we are a very large economy. We appear to be very resilient at this point. The whole dot.com thing did some very good things for this country. The Enron thing is doing some very good things for this country in the way we are reconsidering how we do business.

If, therefore, you kind of posit that if we try to do $190 billion, and it really does not do anything, and it probably will not pass because it will just fritter out, that you just go ahead and do a very large number.

I am not necessarily saying the AARP number, but a very large number, where you have something that seniors will, in fact, be willing to pay, since it is voluntary, and that they do get catastrophic, they do get, as I feel very strongly about, defined, not actuarial, benefits, as you remember, and that you do it. You do it at a very large amount of money, a lot more than $300 billion over 10 years.

Then you look at it and you say, well, we have done something we cannot afford, but you have done it. As you said, it gets very hard to take it back.

Maybe that is a good thing, Bob Kerrey. When we were back at the so-called Clinton health care thing and we were talking about 44 million—37 at that time—uninsured Americans. Seventy-two percent of Americans said, I will pay more in taxes to make sure that everybody gets health insurance. The problem was, they did not mean it.

All kinds of polls came out. Seventy-two percent. It was fascinating. But they did not mean it. They were worried about their own. So that is a way that you eventually get nothing done. We have not really progressed very much, except for the children's health insurance program, on the uninsured. There is no prospect that we will.

So what is philosophically wrong about taking a very large number, doing a prescription drug benefit over a period of 10 years, and then figuring that a lot of things can go right in America, too.

We could be doing very well in this war if certain things happen. Maybe there will be a suppression of terrorism and things will even out a bit where we can afford it. We need to do the public health upgrade and some of the other home and security things anyway.

But you do that and then you are just stuck with it. That is the whole point. But you have got it. Then you say, all right, we have got the deficit, and then there was this big tax cut. The tax cut was $1.6 trillion in amount, and another $1 trillion to pay for it, so that is $2.6 trillion. If we had not done that we would not be having this conversation. We would be passing a prescription drug benefit.

Now, Congress is not going to, and I am not going to, call for a roll-back on the tax cut. But it could be that the President will have to if he is doing both an overseas war, homeland security, and trying to keep people at home filled with some hope, part of which is prescription drug.

Now, although that is a somewhat difference approach, what is wrong with that idea?

Mr. KERREY. It is dumb. [Laughter.] No.

Senator ROCKEFELLER. Tell me why. You basically force the President, at the right time, at the time of his choosing, to pull back on some things like the top one percent, or whatever.

Mr. KERREY. If that was the proposal, the proposal is to say let us delay the tax cut for people over $100,000 a year in order to free up the revenue to pay for a prescription drug benefit, my attitude towards it is different because, all of a sudden, then you can afford to do it. Then you have got the resources and the revenue to be able to pay for it.

But I do think that, to begin by saying, here is the forecasted revenue, if you do not like Dr. Crippen's numbers you go to OMB.

One thing I thought we did a very good job on in the 1990's, is getting to a point where we all at least trusted the numbers.

But whatever the numbers are, they tell you what they think the revenues are going to be and what your expenses are going to be once you build in your budget. I think you have got to live within that. You may say, well, gee, I wish it was larger.

I think it is going to be larger if something happens. But, absent the discipline of saying that you are going to trust the numbers and you are going to live within those numbers, all bets are off. You could run Federal spending up to 100 percent of GDP, I guess, if you wanted to. But I think it would force it in the wrong direction.

To be clear, again, Senator Rockefeller, if the proposal was to say, let us say the prescription drug benefit, and you used the number of $300 billion. Let us say it is $500 billion. Let us say that is the number you have in your mind.

Even though it does not fit in the budget, and even though it is going to increase the deficit, and even though it is going to make the fiscal situation worse, if you are going to take $50 billion a year and you are going to say, what we want to do is we want to increase the number of Americans who are working, and working at higher wages, and we are going to invest in their education, in their training, in their child care, their technology, and the transportation, and all of the other sorts of things that are necessary to produce a more productive economy.

If it was the strategy to increase the productivity of Americans who are in the workforce today and tomorrow that necessitated some loosening of fiscal discipline in order to get it done, I get more interested. That is where we get the money.

The danger, I believe, of putting any expansion of the entitlement programs that you question whether or not you are going to be able to afford it, is that we are not going to be able to tax three workers 25 years from now, we are only going to be able to tax two. We have only got 40 percent of the workforce today that have been to college.

I do not know if you saw the New York Times, as I was flying down today, they were talking about how the unemployment rate is higher for people who did not go to college. At the start of the recession, it looked like the people who went to college were going to be unemployed at a higher rate, but now it is just sort of back to business as usual.

They are the ones that get hurt the most. Well, only 40 percent of the workforce. I mean, yes, I understand college graduates are having trouble finding jobs today because we have got a recession. But they are not having anywhere near as difficult a time finding jobs as high school drop-outs and high school graduates.

So if you were coming to me saying, I want to bend the rules here a little bit in order to invest in the increased productivity of the United States of America so as to be able to increase my base of support for the baby boom generation, then I get more enthusiastic about it.

Senator ROCKEFELLER. Good.

The CHAIRMAN. Thank you, Senator. Thank you very much.

Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

Senator Kerrey, the Concord Coalition has pointed out that prescription drug costs will increase twice as fast as other health care costs. Some say that we ought to be very cautious about creating this prescription drug benefit, and that has been debated and talked about here this morning.

But there are also many that say Congress needs to take bold action. I, for one, believe that the cost savings are greater than what we are being told in a prescription drug plan.

I have seen it in our own household. My father, being a Korean veteran, we did not realize he had access to a veterans prescription drug package which, when we finally figured it out, got him on a regular prescription drug package.

We have seen a decrease in health care costs there, but also an unbelievable benefit that a lot of people out there do not know, particularly a lot of veterans do not know.

But in your view, what is it that Congress could do this year to provide assistance to seniors for these unbelievably increasing prescription drug costs?

And if the argument is that the cost of prescription drugs is increasing more than the use or the prescribing of those drugs, then does the Concord Coalition, in those concerns, suggest that Congress should be considering any pricing constraints in terms of prescription drugs?

Mr. KERREY. Well, first of all, the most important thing the Concord Coalition believes is that there is a connection between increasing debt and increasing borrowing to meet Federal expenditures in the status of both our current and our future economy.

The Congress deserves a great deal of credit, beginning with President Bush's decision to participate in a budget agreement with Congress in the early 1990's, all the way through the time when both the House and the Senate became Republican.

It deserves a great deal of credit for taking us from a point where we were borrowing annually somewhere between $300 and $350 billion a year to a point where we were generating surpluses and paying off the debt. We believe that benefits working families in the United States.

The number I used earlier, Senator, was from last year to this, we have gone to a point where we anticipated having $600 billion worth of publicly held debt. Now it is going to be $1.6 trillion. That is $10,000 per household. It is a huge amount of money.

So that debt, and the interest payments on that debt, have to be born by working families, especially in an environment where there is a lot more—and I do not think you are ever going to change this, and I regret it—enthusiasm for cutting income taxes than there is in cutting payroll taxes.

So working families are always going to shoulder a disproportionate share of deficit reduction. They have got the joy of having their payroll taxes to be used to make the deficit look smaller than it actually was all the way through the 1980's and 1990's, because that is what the payroll tax did.

Then once we got to a point where we had the deficit eliminated, they got the joy of paying off all the debt because we were much more enthusiastic about cutting income taxes.

So the Concord Coalition believes there is a relationship between interest rates and prosperity of the United States by keeping our budget balanced and our fiscal house in order.

We also believe that it is important for us to pay attention if you presume—and I think it is correct—that there is a limit to how much the American taxpayers will allow the Federal Government to withdraw from the economy.

Presuming that limit is 20 percent, it is very relevant for us to pay attention to the growing share of that budget that is growing for mandatory programs, including interest payments. It is painful to look at just the increased interest payments from last year to this. Again, it is on the shoulders of working families on whom right now, in my view, we are under-investing.

So if you respond to one group of Americans and say, you are right, your prescription drug costs are high, I would take that argument. They are unbelievably high and unbelievably burdensome.

Senator LINCOLN. And increasing in a greater percentage every year in the cost and use.

Mr. KERREY. But, Senator, as you know, so is the cost of child care. So is the cost of college. But the difference between child care and college, is you have got to vote on child care and college in appropriations. You do not vote on a mandatory program once it is in place. You do not vote on interest. It is just there and it grows as a percentage of our budget.

Senator LINCOLN. Well, then should it be a combination, perhaps, then of spending restraints as well as——

Mr. KERREY. I would love that. I will check with Bob Bixby over here to see if I am speaking out of school. I would love to see the spending caps back. I would love to see the discipline we had.

Senator LINCOLN. What about pricing constraints?

Mr. KERREY. I am talking about the Congressional budget rules.

Senator LINCOLN. But what if you did a package of a prescription drug with pricing constraints?

Mr. KERREY. Well, I think the market is responding there. I mean, I would just keep beating up the drug companies because they are dropping the prices. Whatever you are doing is working right now.

Senator LINCOLN. But they still increased this year, was it, like 14 percent.

Mr. KERREY. I think it is more like 18 percent.

Senator LINCOLN. Is it 18?

Mr. KERREY. But the problem is, included in that are brand-new drugs. Tom Scully earlier disclosed to all of America that he takes Lipitor. There are all kinds of new drugs that are out there and they are expensive.

I mean, neither the NIH, nor the pharmaceutical companies, are out there saying, my gosh, we have got to find a cure to X and we have got to make sure it is cheap.

Senator LINCOLN. But other countries, in terms of paying the fair share of that research and that development.

Mr. KERREY. There is no question that other countries take enormous advantage of our R&D, and they will even say so. They love copying our R&D. They love taking advantage of the United States of America in that area. So, there is no question in my view.

Senator LINCOLN. Well, I just ask that because I am rapidly hearing more from Arkansans who are dialing a 1–800 number in Canada.

Mr. KERREY. Look, I hear it all the time as well.I am not even in the Senate any longer. I have to negotiate and get health care benefits for my employees and I hear it all the time. I look at the numbers and it is going up very, very rapidly. My own fear is, in that particular case, that price controls would produce a counterproductive result.

Again, I do not think it is small. You all have produced price reductions. The pharmaceutical companies are nervous about price controls, so maybe a few of you need to keep talking about it a while and produce some additional benefit. They are responding to both political concerns and consumer concerns about their prices.

Senator LINCOLN. Thank you.

Senator HATCH. Thank you. Good to see you back, Senator Kerrey.

Mr. KERREY. It is nice to be back.

Senator HATCH. You are looking pretty good, I will tell you.

Mr. KERREY. I do not like that qualifier, pretty. You used to say I looked good.

Senator HATCH. Actually, you have always been pretty. [Laughter.] You are a little more gray, however.

Mr. KERREY. Yes.

Senator HATCH. Listen to who is talking, right?

Let me ask Dr. Crippen a couple of questions, first.

Dr. Crippen, I have heard some real comments on the other side that the Bush tax cuts have caused all these problems, the shortfall of money and so forth.

It was kind of my idea, and my understanding is, those tax cuts are not even in effect yet, other than they have passed.

What has caused this recession? Has it been the Bush administration?

Dr. CRIPPEN. No. The recession certainly was not caused by anything that you or the President did.

Senator HATCH. Did it just begin when President Bush came in? Is that when it began?

Dr. CRIPPEN. The National Bureau of Economic Research says that it began before then—a little before. But the tax cut may have actually helped get us out of a recession sooner than we might have or made the recession shallower, because one of the things you did in the tax bill was to have a significant rebate program—to give lower-income earners, the new 10-percent-bracket folks, rebates. So that may well have helped. But the tax bill did not cause this recession. It probably shortened it or made it more shallow.

Senator HATCH. I want to thank you for your testimony. I have always believed that we should provide prescription drug benefits for all Medicare beneficiaries.

However, your testimony paints a very grim picture, especially if we provide comprehensive drug coverage for all senior citizens.

In my opinion, our first priority should be to provide coverage to seniors who cannot afford prescription drugs. These seniors either have too much money to be eligible for Medicaid, but do not have enough money to purchase their prescription drugs.

On the next panel, we are going to be hearing from Patricia Neuman of the Henry J. Kaiser Family Foundation who says that "most Medicare beneficiaries live on modest incomes, limiting their ability to purchase drugs, and 4 in 10 beneficiaries live on incomes of $16,000 for individuals, and $22,000 for couples."

So you say that the President's proposal will cost $57 billion over 10 years. Now, can you tell us how much it would cost to provide comprehensive drug coverage to low-income Medicare beneficiaries? Even more important, can we afford it?

Dr. CRIPPEN. It would depend, obviously, on any number of things, Senator. But certainly the amounts would be much, much less than the amounts we have been talking about for a universal benefit.

There are already 23 or 24 States that provide, through Medicaid, a fairly good drug benefit for enrollees whose income is below 100 percent of the poverty level. One of the administration's proposals was to raise that income threshold and thereby increase the number of people covered, by several million in any given year.

So the $57 billion or the $77 billion that the administration says it would spend would provide a fair amount of coverage for those with income below 150 percent of the poverty level.

As I said earlier, survey results suggest strongly that even elderly people who do not have insurance still obtain a fair number of prescription drugs—not perhaps enough, whatever that means, and perhaps at great cost to themselves. Nevertheless, they fill about 19 prescriptions a year, whereas those with insurance fill about 30.

So if you are trying to cover a gap, the first gap you may want to look at would be what drugs those folks are not getting and at what cost to their health. Presumably, the low-income folks are in that same group—they are getting fewer prescriptions and they are uninsured—but it is not clear that they perfectly overlap.

So it could be much cheaper to provide a benefit for low-income people and the currently uninsured—about 25 percent of the elderly—than to provide an universal benefit.

Senator HATCH. Senator Kerrey, as you know on the issue of the cost of drugs, just 5 or 6 years ago we were astounded at the costs. It takes about 15 years and about a half a billion dollars, and probably 6,000 or more misses, to achieve a major drug. Today, that number has jumped to $800 million per drug, in the eyes of a lot of people who seem to understand it.

I suspect that one of the problems is that the FDA has not been revitalized. We passed the Hatch FDA Revitalization Act better than 10 years ago, as I recall, that was to create a single, unitary campus with state-of-the-art equipment that would allow them to acquire some of the best minds in the business. We have not hired, in my opinion, a new research scientist in the last 20 years, or even 30 years, because they do not want to work for FDA.

Have you factored that into your thinking as to how we might audibly bring down the price of drugs by getting even better people to come into the agency and to revitalize the agency, and of course bring down the total time it takes to develop these drugs so that the prices are not so high?

Mr. KERREY. Yes. Presuming, Senator—and I do not want to put words in your mouth, but I have heard you say it before—that we

do not surrender any ground on the health and safety of consumers, which I have heard you speak very eloquently on.

Senator HATCH. No, that is right. It seems to me, if we get the best people in there——

Mr. KERREY. Yes. I would say, absolutely, yes. The role played by the FDA in making certain that we keep our competitive edge, as well as making certain that the American people and the rest of the world really benefits from the R&D that is being done in this country, is enormous. The more efficient that they get, the better the people are that are there, the more likely it is that you are going to have happier results down the line.

I would say, in addition to what Dan said earlier in answer to your question, one of the great things about Medicare and Social Security is that it is not welfare. I think you have been very careful with both programs. I have been involved with the debate, and it gets real intriguing to income tests, and all that sort of thing. But once you income test, the program changes.

Once the program changes to become welfare you lose the intergenerational importance of it and the value of the intergenerational support, but you also significantly deteriorate people's attitudes towards it.

So, as appealing as it becomes to try to target on a prescription drug benefit, if one gets added, I hope it is added to all of Medicare. I have declared my preference for structural change in Medicare and my preference for structural change in——

The CHAIRMAN. We are going to have to truncate the questions and the answers here.

Mr. KERREY. You have a vote?

The CHAIRMAN. No. There is another kind of a vote.

Senator HATCH. My time is up.

Let me just make a suggestion to Dan Crippen. Dan, I estimated it to be about $1 billion when we came up with the FDA revitalization bill, and that is on the books. I would like you to just take a look at that and see what you think the cost would be today. I estimate it would probably be around $2 billion to do that, to consolidate.

They are in 27 different locations, some of them converted chicken coops. It is unbelievable. There is no incentive for people to come in and work and to revitalize the agency. I think that is one way we might be able to bring down drug costs.

The CHAIRMAN. Well, thank you very, very much. I know, Senator, it is a busy job being president of the university, and you have taken your time to come and help here.

Mr. KERREY. It is good to see you. Thanks.

The CHAIRMAN. I deeply appreciate it.

Mr. KERREY. You look pretty good, Senator.

The CHAIRMAN. Yes. [Laughter.]

Senator HATCH. So do you.

The CHAIRMAN. Thank you, Dr. Crippen, very much. We appreciate it.

I now apologize deeply to the next panel for the delay in getting to you. Mr. Novelli, executive director and CEO of AARP, and also Patricia Neuman, who is vice president and director of the Medicare Policy Project in Washington.

Again, I apologize. I am very sorry that the earlier panels took so long. There were a lot of questions asked, a lot of information there. It is regrettable, and I hope you understand.

Also, for the good people representing providers and seniors, near the end there are not as many Senators here. But, nevertheless, we have staff, we have the TV monitors on. You can speak very articulately to the world. So, for all intents and purposes, you will be heard just as much.

Why do you not begin, Mr. Novelli?

STATEMENT OF BILL NOVELLI, EXECUTIVE DIRECTOR AND CEO, AARP, WASHINGTON, DC

Mr. NOVELLI. Thank you very much.

Mr. Chairman, we would like to thank you for inviting AARP to address the need for Medicare drug coverage in this year's budget.

As you know, I am relatively new in my job but I have already heard a lot from our members about their drug coverage wherever I have traveled around the country.

Prescription drug coverage in Medicare is an urgent priority for our 35 million members and for virtually all older Americans. We are doing a lot of research and we are talking regularly with these people, and with the general public. What I would like to do is just share with you briefly what we have learned so far.

Our older members now find their drug coverage options increasingly limited, expensive, and unstable, or even unavailable. It is important to note that this is a problem for all older Americans, not just a problem for those with low incomes.

A recent survey we conducted found that younger adults—and I am talking about those 45 and older—are just as concerned. They know that drugs are a part of modern medicine and they have become just as important as hospitals and doctors for staying healthy, and oftentimes for staying alive.

These younger adults are concerned about their parents and they are thinking about their own later years. They understand that you do not have adequate health insurance today if you do not have adequate drug coverage.

As you know, the challenge of crafting a workable Medicare drug benefit is enormous. You have talked about that all morning. To succeed, it has got to attract enough voluntary enrollees to make it a viable program.

Now, I think it is clear that our members expect to pay their fair share. But they are going to sit down at their kitchen tables and they are going to carefully consider whether the package that is offered provides real value that they are willing, and they are able, to pay for.

We are very pleased and appreciative that the President has made Medicare drug coverage for older Americans a priority for his administration, and he is working with you on this issue.

We are well aware that today's budget picture is certainly less optimistic than a year ago, but we have got to ensure that there is adequate funding for prescription drugs.

A program funded inadequately, that is with low benefits and high premiums, is not going to meet that kitchen table test. Not enough beneficiaries will enroll in it, and that means that drug

benefit design has got to be based on good policy and not just on budget ceilings.

That is why AARP is calling for a flexible budget approach, a word that has been used a lot today. We are asking Congress to earmark at least as much as was set aside last year in the budget resolution for prescription drugs and for Medicare modernization, adjusted for inflation and for a more expensive year. This comes to about $350 billion.

But this, in itself, is not likely to be enough. Our polling, our focus groups, and our other studies show that only a minority of Americans 65 and over say they are likely to participate in the kind of benefit that that amount can buy.

That is why we are also recommending that you consider creating a reserve fund of about $400 billion. We see that as roughly an amount equal to the 10-year surplus in the Medicare Part A trust fund.

At this point, we do not know what a workable, affordable benefit will ultimately cost. But having access to that reserve, which you can allocate as needed, will provide Congress with the necessary flexibility to create a drug benefit that will succeed in the real-world marketplace.

There are two more elements that are crucial in a successful Medicare drug benefit. The first, is cost containment measures that help control drug spending in order to keep the benefits sustainable over the long run.

We believe that the government, health care consumers, and AARP all have a role to play here, so later this month we are going to launch a national education program directed to our members and the general public about the wise and the safe use of medications, including generic drugs.

The second important element is bipartisan cooperation to arrive at a meaningful benefit this year. Medicare provides security to all American families, and we at AARP pledge to provide assistance in every possible way we can as you move forward.

We are going to be flexible, cooperative, open to new ideas, and realistic. Our members need a plan this year that will pass that kitchen table test. The urgent needs of older and disabled Americans who are asking for help with drug coverage are enormous, and these needs are growing.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Novelli.

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

The CHAIRMAN. Dr. Neuman?

STATEMENT OF PATRICIA NEUMAN, Sc.D., VICE PRESIDENT AND DIRECTOR, MEDICARE POLICY PROJECT, WASHINGTON, DC

Dr. NEUMAN. Thank you, Mr. Chairman.

I am pleased to be here to testify on prescription drug discount card programs and their implications for seniors.

According to recent estimates, 38 percent of all Medicare beneficiaries were without drug coverage in the fall of 1999. Seniors without drug coverage are at risk. They fill fewer prescriptions, they still pay more out of pocket for their medications, and with

the rise in drug costs and the erosion of supplemental coverage, these problems are expected to grow in the future.

Today, discount card programs vary widely in terms of how they operate, the savings they offer, and ultimately their impact on consumers, according to a study prepared by Health Policy Alternatives for the Kaiser Family Foundation.

Most of these programs are relatively new. They tend to be sponsored by private entities such as pharmacy benefit managers and retail stores. Many market directly to consumers, but also through intermediaries such as employers, insurance companies, and associations. In general, they are not considered insurance and they are typically not regulated.

Most discount card programs are marketed to the general public regardless of income or age. Some offer additional benefits, such as dental and vision discounts. Typically, there is an enrollment fee and consumers are free to sign up for as many programs as they would like.

Discount card programs get savings off of full retail price by negotiating lower pharmacy dispensing fees, by using the Internet and mail-order services, and by obtaining volume discounts from manufacturers.

Most of the discounts result from concessions on pharmacy markups and dispensing fees rather than from manufacturer rebates. Among the programs that do get rebates, there is considerable variation in the degree to which these rebates are passed on to the consumers.

Based on a review of existing programs, it is difficult to assess how effectively they lower seniors' drug costs. The recent GAO report indicates that discount cards can lower costs. However, the discounts vary widely across programs and from drug to drug.

The overall magnitude of savings depends on the number of people with cards, the discounts offered and on which drugs, and how frequently individuals use their cards. Because much of this information is unknown or considered proprietary, it is difficult to derive accurate estimates of savings. For a given individual, the potential savings could depend on the specific drugs they take and for how long. The bottom line is that a card that is good for one senior may not be good for another.

At the same time, comparison shopping is not easy today. There is currently no central source of information to compare costs across programs, so seniors must consult each program individually.

While the Internet may make this process easier, many programs do not actually list their prices on the Internet. Of course, only 16 percent of seniors use the Internet regularly.

Even if seniors are able to get cost information, programs display discounts in a variety of ways. Some show the actual cost of the prescription, some present the discounts as the retail price minus a certain percentage.

Others show the dollar amount of the discount without disclosing what amount the consumer would actually pay. Comparisons are further complicated by frequent fluctuations in drug prices, enrollment fees, and postal fees for mail-order options.

While discount cards may lower costs, they are unlikely to make drugs significantly more affordable for seniors living on fixed incomes. Take, for example, an elderly woman who uses four commonly prescribed medications and is living on about $1,300 a month, or $16,000 a year, which is the mean income for an elderly woman.

As Exhibit 8 of the testimony shows, she would save money by using a discount, but would still spend about 25 percent of her monthly income filling her prescriptions. By contrast, her prescriptions would account for only 8 percent of her income if she had drug coverage under an FEHBP PPO plan.

Last week, the administration proposed a new Medicare-endorsed prescription drug discount card program as an incremental step toward a Medicare drug benefit. The administration would allow discount card sponsors to use a Medicare emblem for marketing purposes. This approach has the potential to lower costs, provide better comparison information, and improve quality, yet still poses questions.

First, would this approach result in greater savings for seniors? Given the challenges of estimating savings from these programs today, this question is difficult to answer.

New Medicare discount card programs could lower costs if the Medicare endorsement helps sponsors attract more beneficiaries and negotiate steeper discounts. If, however, these discounts are not passed through to consumers or do not apply to all drugs, the value to the individual would be compromised.

Second, would the new initiative facilitate cost comparisons? Providing consumers a central source of information could be a significant improvement over the status quo, provided that information is presented in a consumer-friendly way.

Third, would discount card sponsors be required to meet minimum standards? Given the vulnerability of the Medicare population and the implications of using Medicare's valuable seal of approval in marketing materials, appropriate and enforceable standards to ensure that Medicare cards are offered by reliable sponsors—and that sponsors deliver at least a minimum discount—could improve consumer protections.

Finally, would this approach make prescription drugs more affordable? As the administration has noted, the proposed discount card program would not deliver the same level of savings as a full Medicare benefit.

Recent public-opinion research indicates strong interest in discount cards, but making prescription drugs affordable for seniors remains a high priority. A Medicare discount card program could lower drug costs, but it is not a substitute for a meaningful drug benefit.

Thank you.

The CHAIRMAN. Thank you very much, Dr. Neuman.

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

The CHAIRMAN. Mr. Novelli, you have sat patiently, listening to the previous panelists. What do you say to those, particularly Senator Kerrey and those who represent the Concord Coalition, who

say, my gosh, this is going to cost so much, we are going to cause more problems down the road than we are going to solve?

What do you say to them, particularly to those who are, say, age 30, 35, 40 today and worried about whether they are going to receive any benefits at all because the program is just going to go belly-up by the time they reach retirement.

What are some of your reactions to all of that?

Mr. NOVELLI. I think he laid out the problems extremely well. What you are wrestling with, is a question of priorities. It is a question of tradeoffs. It is a question of intergenerational thinking. I think he laid out the problems very well.

From our standpoint, our research shows that younger people want drug coverage for older people in this country. They are worried about their parents and their grandparents. They basically have an intergenerational view.

So, really, in our mind it is not a question of thinking about it just that way, but thinking about, what is it really going to take to have quality of life for Americans? As we all know, you cannot have modern medicine without prescription drug coverage.

And even though it is very difficult to cost, as Senator Lincoln was pointing out, there are some real potential savings, both in quality of life and in improving the lives of older people, but even beyond that, in keeping people out of emergency rooms, out of hospitals, out of nursing homes. That will make a real difference in our Nation.

So, we have to think about this very broadly, and it is a very difficult issue for you all to take up. But, as I also pointed out, we need to get these people to buy in, so putting all the pieces together, as you talked about earlier, is the big challenge.

The CHAIRMAN. What does your research show as to what seniors can live with in terms of premiums, co-payments, and all of that?

Mr. NOVELLI. Well, we obviously have not tested everything there is. There are a lot of creative ideas that I know you all are going to come up with. We are pledging to take any and all ideas to our members and to test them out.

But just to give you an example, we did a recent poll and what we found is that only about a third of those 65 and older would likely participate in a drug plan that included a $35 monthly premium, 50 percent co-insurance, a $200 annual deductible, and a $4,000 stop-loss.

So, we are talking about bringing in only about one-third of all participants if you had a program at about that price.

We know that the expectations that those people have need to be managed. I mean, we just cannot come up with a program that goes through the roof, but at the same time we have to try to meet the needs of people.

The CHAIRMAN. Among those components, which one is most important?

Mr. NOVELLI. We think it is the premium. We think the premium drives the other aspects of the program.

The CHAIRMAN. And so what is the high and low of a premium? What is the range here?

Mr. NOVELLI. Well, we know definitively that a $50 premium is not going to cut it. A $35 premium, as I said, brought in about one-

third. It is difficult to say, but we are probably in the range of $30 to $35, and hopefully we could work with something like that. If we could go lower it would be great, but again you are faced with some tough choices.

The CHAIRMAN. All right. Let us say, $30 to $35, and the other components are reasonable. What does that calculate to? What is that?

Mr. NOVELLI. We do not know. A program like that really has not been costed out. I mean, people have used numbers of $500 billion. We really do not know at this point.

The CHAIRMAN. Dr. Neuman, you have done a lot of research, too. What have you found as to what people want? It is our thought—that is, many members in the Congress—that we have learned recently that seniors have very high expectations.

In fact, there is a feeling that it should be virtually free, which is impossible. But, to the degree that is true, to the degree that your research shows that is what seniors think, please, I wonder if you could confirm that. Second, if you can, or to the degree that you can, give us some thoughts as to how we bridge that gap.

Dr. NEUMAN. Last year, the Foundation commissioned focus groups conducted by Geoff Garin and Bill McInturff, because we wanted to get a better understanding of where the public was and how the public was reacting to the Medicare prescription drug debate here in Washington.

I guess what we learned in those focus groups is that there appears to be a disconnect between the debate happening here in Washington and what people were really thinking when they heard the words "Medicare modernization," "Medicare reform," and "prescription drug improvements for Medicare."

In these focus groups, when they were asked about Medicare reform and modernization, everybody thought that meant more benefits. If you are going to modernize and improve Medicare, what that means is a prescription drug benefit, dental benefits, and all of the other things that are not currently covered by Medicare.

So, that was the first observation. That was true for the elderly and the general public in terms of expectations.

A second observation is that, when there was a discussion about the type of benefit that might be offered, there was an expectation that the benefit would look a lot like what most workers get today. So, we then went to the next level and started talking about features of a possible drug benefit. There was a fairly negative reaction to a $50 premium, for example.

I think that all of the researchers who were involved characterized it as "sticker shock," because the public, including the non-elderly and the elderly, were really not expecting a Medicare drug benefit to have such a high premium.

The CHAIRMAN. What do people pay today in the private sector? What kind of premiums, co-pays, et cetera? Or in some other program. Let us say, under VA or under Tricare.

Dr. NEUMAN. Typically, people do not pay a premium for just prescription drugs, so that is part of the problem. Mostly, people pay a premium for their health insurance, so they do not see a separate premium that would apply to their prescription drug assistance alone. So, I do not know that there is a number out there that

can help us, because most plans do not have a separate drug premium.

The CHAIRMAN. Does that imply that perhaps we should go down that road, more insurance, health insurance that includes a drug benefit? Are we perhaps touting something that is not going to work, a separate prescription drug benefit program, rather than, on the other hand, separately trying to figure out how to get more health insurance to more people?

Dr. NEUMAN. Right. I mean, I guess the challenge is financing the new benefit, and a premium is one way to lower the cost to the Federal Government. But, including a drug benefit in traditional Medicare would probably help in terms of presenting costs and benefits in a more integrated way.

The CHAIRMAN. Do you have any thoughts on that point?

Mr. NOVELLI. Yes, I agree. I think that what we have now is a situation where an awful lot of people in the private sector, and their physicians, do not know what drugs cost. To the degree that people can understand what they cost, we will probably have wiser and safer use of medications. So, finding a way to really connect people, connect costs and usage, is an important thing to consider.

The CHAIRMAN. What are your thoughts about the cost of drugs? There has been a lot of talk in here about high costs. Some suggest some pricing mechanisms with respect to pharmaceuticals. Your thoughts?

Mr. NOVELLI. Well, our research shows that there are very few people out there who want to see price control. It is just not something that is really very feasible, and the public does not support it.

At the same time, what we have here are drug prices that are rising very, very fast, even faster than general health care costs. There have got to be some ideas for cost containment.

I suggested one earlier when I said that we are going to do a big education program directed to our members in the general public, and we are going to talk about wise use of medications and try to put a lot of emphasis on the potential for generic drugs. We have to talk to physicians about that as well.

That is one kind of cost containment that we can think about. There are probably others that can go along with that. But if we just have a benefit that keeps going up as drug costs rise, it is not going to be sustainable over the long term. We have to look at both sides of the equation.

The CHAIRMAN. I see. So, education is one component in addressing drug costs. What else? I mean, various entities, States, the Medicaid program, and others are trying to get drug costs down.

Mr. NOVELLI. Well, I think Senator Hatch was referring to it earlier. The issue of patents and other loopholes in the current laws dealing with generic drugs probably needs to be looked at as well.

The CHAIRMAN. Yes. Dr. Neuman, any thoughts on the price of drugs?

Dr. NEUMAN. Well, there are a variety of options that have been discussed in recent years as drug prices have gone up. I think we need to take a look at each of these options and consider what their potential effects are in terms of controlling the growth in pharmaceutical spending, and then also what they would mean for con-

sumers, to be sure that they do not have unintended adverse effects in terms of limiting access to the drugs that people need.

The CHAIRMAN. Mr. Novelli, I am a little surprised you did not sit down here and advocate, $750 billion, $800 billion for a prescription drug benefit. Why?

Mr. NOVELLI. I am sorry Senator Breaux is not here, because I wanted to respectfully tell him that we did not advocate $750 billion for a drug benefit. What we basically said, was we think that the research shows pretty clearly that $300 billion is not the right number. It is not going to work at that level.

So we suggested that you all consider a reserve so that you would be able to craft a benefit that would really work in the marketplace and would pass that kitchen table test. There are other Medicare reforms that that reserve could help to pay for as well.

We are realistic. And we are not just flexible, but open to all kinds of new ideas. As I said, as you do your work, we will take proposals out to our members, test them, and we will bring them back and work with you in any way we can.

The CHAIRMAN. Well, I appreciate that, Mr. Novelli. We tried reserves, Social Security, lock boxes, and so forth. The trouble is, Congress can always change the law the next day, so they are not protected as well as people might think they are, or were at that time.

I do encourage you to keep coming up with ideas, because the more ideas, the better it is. Someone said, and I think it is true, you have to have about 9 or 10 bad ideas before you can come up with a good idea. So if you can give us a bunch of them, one of them is going to probably turn out to be pretty good.

Mr. NOVELLI. Well, we will do our best.

The CHAIRMAN. Thank you.

Thank you all very much. I appreciate your patience, and thank you for your contribution.

Mr. NOVELLI. Thank you for your leadership on this issue.

Dr. NEUMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

The hearing is adjourned.

[Whereupon, at 1:11 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

CBO TESTIMONY

Statement of
Dan L. Crippen
Director

Projections of Medicare and Prescription Drug Spending

before the
Committee on Finance
United States Senate

March 7, 2002

Mr. Chairman, Senator Grassley, and Members of the Committee, I am pleased to be here with you today. This morning I will discuss the Congressional Budget Office's (CBO's) projections of Medicare spending for 2003 through 2012 and compare them with those of the Administration. I will then summarize CBO's estimates of the cost of the President's budgetary proposals for Medicare. Last, I will describe CBO's new projections of prescription drug spending for the Medicare population and outline some general approaches for providing prescription drug coverage through Medicare.

THE IMPACT OF CHANGING DEMOGRAPHICS ON SPENDING FOR MEDICARE

Before describing CBO's projections, I would first like to underscore that the long-range picture of federal spending that I described to you last year remains unchanged. Looking at Medicare's near-term situation and proposals to increase payments to providers or to add a prescription drug benefit within the context of the program's long-term financial pressures can provide a beneficial perspective.

The aging of the baby boomers has dramatic fiscal implications for Medicare (see Figure 1 on page 16). If the nation spent the same fraction of gross domestic product (GDP) on each Medicare beneficiary in 2030 as it does today—a proposition reflecting only the increased number of beneficiaries in the program at that point—spending for Medicare would grow from today's 2.3 percent share of GDP to 4.5 percent by 2030. However, the fiscal implications of the baby boomers' aging are compounded by the fact that health care costs measured per beneficiary routinely grow significantly faster than does the economy measured on a per capita basis. As a result, if current law remains unchanged, CBO expects that spending for Medicare will climb to 5.4 percent of GDP by 2030.

Also projected to rise is spending for the "big three" entitlement programs—Social Security, Medicare, and Medicaid—taken as a whole. Between now and 2030, such spending as a share of GDP will virtually double. Expenditures for those programs will grow from 7.8 percent of GDP to 14.7 percent by 2030 (see Figure 2).

That increase in spending of almost 7 percentage points will occur under current law. Proposals to increase payments to providers of services in the Medicare program or to expand the program's benefits through prescription drug coverage would exacerbate the long-term budgetary pressures projected for the next several decades. As this Committee knows, paying for those increased costs will require either dramatic reductions in spending, sizable increases in taxes, or large-scale borrowing.

Within the context of that longer-term perspective, I will now turn to CBO's projections of Medicare spending for the next 10 years, which we have just completed updating as part of our analysis of the President's budgetary proposals. CBO's new baseline projections of Medicare spending over the 2003-2012 period are lower by about $80 billion relative to its estimates in January. The revisions, which are mainly the result of new information, leave CBO's overall estimate for the period about $225 billion higher than the Administration's. That amounts to a difference of about 7 percent over the 10-year projection period, but CBO's and the Administration's estimates differ by only 4 percent over the five-year budget window. And regardless of their differences, both CBO's and the Administration's baseline projections reflect underlying forces that are likely to continue to exert upward pressure on spending in the Medicare program.

CBO'S PROJECTIONS OF MEDICARE SPENDING UNDER CURRENT LAW

CBO projects that gross mandatory outlays for Medicare will total $248 billion in 2002 (or 2.4 percent of GDP) and $3.6 trillion over the 2003-2012 period, reaching 2.8 percent of GDP by 2012 (see Table 1). After deducting projected premium payments by beneficiaries of $26 billion in 2002 and about $400 billion over the 10 years, CBO estimates that net mandatory spending for Medicare will total $223 billion in 2002 and $3.2 trillion from 2003 through 2012 (see the table below).[1] All of CBO's projections incorporate the assumption that current law remains unchanged.

Projected Growth of Spending and Payments to Medicare Service Providers

CBO projects that net mandatory spending for Medicare will grow at a rate of 7.1 percent in 2002 and at an annual average rate of 6.6 percent over the 2003-2012 period. Those rates take into account a shift in the timing of some payments, which is described below.

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1. In addition, the costs of administering the program, which are funded annually by appropriations, will amount to an estimated $3.6 billion in 2002.

SUMMARY OF CBO'S MARCH 2002 BASELINE PROJECTIONS
OF MANDATORY MEDICARE OUTLAYS (By fiscal year)

	Billions of Dollars		Average Annual Rate of Growth, 2003-2012 (Percent)
	2002	2003-2012	
Gross Mandatory Outlays	248	3,590	6.9
Premiums	-26	-413	8.4
Net Mandatory Outlays			
Unadjusted	223	3,177	6.7
Adjusted for timing shifts[a]	226	3,177	6.6

SOURCE: Congressional Budget Office.

a. Outlays are adjusted to eliminate the effect of accelerating payments to group plans from October to September in some years.

In recent years, the annual growth rate of spending for Medicare has varied considerably. Growth averaged 1.2 percent annually during the 1997-2000 period but then shot up to 10.3 percent in 2001. That jump stemmed in part from a provision of the Balanced Budget Act of 1997 (BBA) that accelerated $3 billion in payments to group plans (mainly Medicare+Choice) from October to September 2001—or from fiscal year 2002 to fiscal year 2001. (Another reason for the resumption of significant growth in 2001 was that by that time, Medicare had absorbed the substantial changes in payment rules enacted in the BBA. Other sources of growth were increases in payment rates and other changes enacted in the Balanced Budget Refinement Act and the Benefits Improvement and Protection Act.) Adjusted for the shift in group-plan payments, the underlying rate of growth in 2001 was 8.7 percent.

Over the next decade, CBO expects several factors to play a major role in the program's spending growth. Those factors include rising enrollment in Medicare, automatic increases in payment rates in the fee-for-service sector (to adjust rates for the rising prices of inputs), and changes in the use of Medicare's services, which will lead to more services being furnished per enrollee and to a shift in the mix of services toward those that are higher-priced and (often) more technologically advanced. In part offsetting the effects of those spending components will be smaller updates (adjustments) to the rates paid to Medicare+Choice plans relative to updates to rates in the fee-for-service sector. (Overall, CBO expects that spending for Medicare+

Choice and other group plans will decline through 2006 and then grow slowly, returning to its 2001 level by 2012.)

The growth rates of Medicare's payments for services vary for particular types of Medicare service providers. Payments to hospitals for inpatient services and payments to physicians, which account for two-thirds of outlays, are the slowest-growing components of spending in the fee-for-service sector, respectively averaging 6.3 percent and 5.4 percent annually in CBO's baseline projections through 2012. By contrast, the rates of increase in payments for other services—for example, those provided by home health agencies and nonphysician professionals—are projected to average 9 percent to 16 percent annually.

Changes in CBO's Baseline Projections Since January

As I mentioned earlier, CBO's March baseline projection of $3.2 trillion in net mandatory spending for Medicare over the next 10 years is about $80 billion—or 2.5 percent—lower than the projection of that spending made in January. Three factors account for that overall revision:

- A reduction of about $30 billion in projections of payments to Medicare+Choice plans. That change reflects the Administration's announcement in January of preliminary Medicare+Choice payment rates for 2003 and updates to CBO's projections of enrollment in those plans.[2] (CBO now projects that the percentage of Medicare enrollees in Medicare+Choice plans will decline from 15 percent in 2001 to 8 percent by 2012.)

- A reduction of about $35 billion in projections of payments for hospital outpatient services. That change reflects the Administration's announcement implementing lower "pass-through" payments for certain new technologies used in delivering services, coupled with an analysis of updated data on the cost of Medicare's "buying down" (contributing more to) coinsurance paid by beneficiaries for hospital outpatient services.

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2. For its January projection, CBO assumed that, overall, payment rates for Medicare+Choice (M+C) plans would grow at the same rate as spending per capita in the fee-for-service sector. CBO now estimates that M+C payment rates in all areas will increase by 2 percent in both 2003 and 2004. Rates in areas subject to a "floor" amount will increase by more than 2 percent in 2005 and grow with fee-for-service spending in subsequent years, but all other rates will increase by 2 percent annually until they reach the level of the floor amount or a 50/50 blend of local and national rates. (CBO estimates that the proportion of payments made at floor amounts or at 50/50-blend rates will increase from about 40 percent in 2005 to 95 percent by 2012.)

- A reduction of another $15 billion in projected spending to better reflect the changing age distribution of Medicare beneficiaries, an improved method for constructing price indexes for projecting updates to payment rates, and the effects of revised projections of outlays on the premiums paid by beneficiaries.

COMPARISON OF CBO'S AND THE ADMINISTRATION'S MEDICARE PROJECTIONS

The Administration's baseline estimate of $3.0 trillion in net mandatory spending for Medicare over the 2003-2012 period is about $225 billion, or 7 percent, lower than CBO's projection for the same period (see Figure 3). For 2003, the difference between the two projections amounts to 1.8 percent; over the 2003-2007 period, the difference is 4.2 percent. The Administration projects that net mandatory spending for Medicare will grow at an average annual rate of 5.4 percent through 2012, in comparison with CBO's projected (and adjusted) rate of 6.6 percent (see Table 2). The Administration's projection shows spending growing more slowly than that 10-year average through 2006 (average annual growth of 4.0 percent) and more quickly after 2006 (average annual growth of 6.4 percent). The pattern of growth in CBO's projection is similar. Rates are relatively low through 2006 (averaging 5.7 percent a year), and higher after 2006 (averaging 7.7 percent a year). The factors that contribute to the difference between the two projections—which, in the context of Medicare spending, is not large—are discussed in Appendix A.

CBO'S ESTIMATES OF THE COSTS OF THE PRESIDENT'S BUDGETARY PROPOSALS FOR MEDICARE

The President's budgetary proposals for Medicare include two major components: a Medicare-funded program that would give states the option of providing prescription drug benefits administered by their Medicaid programs to Medicare beneficiaries whose income is below 150 percent of the poverty level, and an allowance of $116 billion over the 2006-2012 period for a "Medicare Modernization" program. As a temporary measure, pending implementation of the modernization program, the President proposes to increase the payment rates for Medicare+Choice plans during the 2003-2005 period. The President's budget also includes three provisions to reduce Medicare spending—first, by establishing competitive bidding for some durable medical equipment; second, by adding new options for supplemental insurance (medigap); and third, by strengthening requirements for insurers that process Medicare claims to report beneficiaries for whom Medicare might be the secondary payer.

CBO estimates that the President's proposals would increase spending by $1.6 billion in 2003 and $169 billion over the 2003-2012 period. In contrast, the Administration estimates that those provisions would increase spending by $190 billion over 10 years.[3] Nearly all of the difference between the two numbers lies in estimates of the cost of offering coverage for prescription drugs to low-income Medicare beneficiaries. The difference arises largely because of differing assumptions about how many beneficiaries would participate in the benefit and what, on average, those benefits would cost.

Medicare Modernization and Medicare+Choice

The Administration has stated that it will work with the Congress to develop legislation to modernize Medicare, including providing coverage for prescription drugs and preventive health care services and protecting beneficiaries from catastrophic costs. In its analysis of the President's budgetary proposals, CBO used the Administration's estimate of $116 billion for the Medicare Modernization proposal because that proposal lacks sufficient details for CBO to develop an independent estimate.

Offering beneficiaries a choice among multiple health plans is an important element of a modernized Medicare, according to the Administration. To encourage health plans to participate in Medicare, the President's budget contains a proposal that, beginning in 2003, would increase the level of payments to Medicare+Choice plans and establish incentive payments to encourage new or existing plans to expand into new geographic markets. CBO estimates that those provisions would increase spending by $3 billion over the 2003-2005 period, which contrasts with the Administration's estimate of nearly $4 billion. The Administration (and CBO) did not estimate the cost of the provisions beyond 2005 because the budgetary effects in subsequent years are included in the $116 billion allowance for modernizing Medicare.

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3. CBO assumes that the components of the President's budgetary proposals need not sum to $190 billion over the 10-year period. As a result, CBO's lower estimate, relative to the Administration's, of the President's proposal for a prescription drug benefit for low-income beneficiaries does not mean that additional funds would be available for Medicare modernization.

Prescription Drug Benefits for Low-Income Medicare Beneficiaries

The President's budget includes a proposal that would give states the option of providing prescription drug benefits to certain low-income Medicare beneficiaries whose income is below 150 percent of the poverty level. The benefits would be administered through the beneficiaries' state Medicaid programs, which Medicare would reimburse for the costs of the program. States would have considerable flexibility in determining the drug benefits that would be provided, the amounts that beneficiaries would pay in the form of premiums or copayments, and any restrictions on eligibility for individuals with assets. Beneficiaries covered by the proposal would receive only prescription drug benefits; they would not be eligible for the full package of benefits under Medicaid. The federal government would reimburse the states at the usual matching rate for Medicaid (57 percent, on average) for spending on beneficiaries whose income falls below the poverty level. The matching rate would be 90 percent for spending on beneficiaries between 100 percent and 150 percent of the poverty level.

CBO estimates that this proposal would increase spending by a total of $57 billion over the 2003-2012 period, whereas the Administration projects a cost of $77 billion over the same span. Differing assumptions about rates of participation and per capita costs (see Appendix B for more information) are the main reason that CBO's estimate differs from that of the Administration.

Provisions to Reduce Spending by the Medicare Program

The President's budget also contains several provisions that would reduce Medicare spending over the 2003-2012 period, including:

- A proposal for a nationwide competitive-bidding system that would encourage companies to sell durable medical equipment at prices lower than those Medicare currently pays. Both CBO and the Administration estimate that this proposal would decrease Medicare spending by approximately $4 billion over the 10-year period.

- A proposal to add two private medigap plans with high deductibles to the 10 standard medigap plans already available to beneficiaries. Enrollees in the new plans, which would provide catastrophic coverage, would probably use fewer Medicare-covered services because the plans would not cover as much of beneficiaries' initial cost sharing as many current medigap policies cover. Both

CBO and the Administration estimate that this proposal would reduce Medicare spending by approximately $1 billion over the 2003-2012 period.

- A proposal requiring that insurers and group health plans periodically report to Medicare those beneficiaries for whom Medicare could be the secondary payer. Both CBO and the Administration estimate that this proposal would decrease Medicare spending by approximately $1 billion over the 10-year period.

PROVIDING COVERAGE FOR PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

CBO has analyzed data on beneficiaries' current spending for prescription drugs and developed preliminary projections of spending for outpatient drugs not currently covered by Medicare. Several approaches to providing drug coverage may be suggested by those data. However, in considering ways to provide a prescription drug benefit, a key factor to keep in mind is the implication of CBO's projections for the Medicare program.

Beneficiaries' Current Spending for Prescription Drugs

CBO's analysis of Medicare's Current Beneficiary Survey suggests that in 1999, one-quarter of the Medicare population had no prescription drug coverage, although 75 percent had coverage for at least part of the year. On average, the share of their drug expenditures that Medicare beneficiaries paid out of pocket was nearly 40 percent—the same share paid out of pocket by the U.S. population as a whole (see Figure 4). But because Medicare beneficiaries are generally elderly or disabled, they are more likely to have chronic health conditions and to use more prescription drugs than the general population: consequently, nearly 90 percent filled at least one prescription in 1999. Medicare beneficiaries made up almost 15 percent of the population that year, yet they accounted for about 40 percent of the more than $100 billion spent on outpatient prescription drugs in the United States.

Those factors suggest that growth in spending for prescription drugs has a larger financial impact on the Medicare population than on other groups in the population. Nevertheless, overall statistics mask a wide variety of personal circumstances. In 1999, for example, nearly 30 percent of Medicare beneficiaries obtained coverage for prescription drugs through employer-sponsored retiree benefits, and another 16 percent had coverage through state Medicaid programs. Although the extent of coverage by

employers and state Medicaid programs varies considerably, in general, those kinds of plans typically include relatively low deductibles and small copayments. About 11 percent of beneficiaries had drug coverage through individually purchased medigap policies in 1999, but that coverage tends to be much less generous, with higher deductibles, coinsurance of 50 percent, and annual limits on benefits.[4] In 1999, 25 percent of Medicare beneficiaries had no drug coverage at all, paying out of pocket for all of their spending on drugs.

CBO's Projection of Prescription Drug Spending for the Medicare Population

Last May, CBO estimated that spending by or on behalf of Medicare enrollees for outpatient prescription drugs not covered by Medicare would total $1.5 trillion between 2002 and 2011 (see Table 3). This year, CBO's preliminary projection for the same period is $1.6 trillion, or about 8 percent higher.

However, CBO's estimate of spending for prescription drugs over the current 10-year projection period of 2003 through 2012 is roughly $1.8 trillion—or 21 percent higher than last year's projection for the 2002-2011 period. Nearly two-thirds of that increase simply reflects the shift in the so-called projection window, which effectively substitutes a high-cost year (2012) for a relatively low-cost one (2002). The remaining growth reflects changes to CBO's estimates of how much, on average, is spent on a Medicare beneficiary to purchase prescription drugs both today and in the future.

Note that the projections I have just described are preliminary in nature. In developing them, CBO used information from its March baseline projections of Medicare spending, which were released last week. We have been working quickly to prepare estimates of prescription drug spending because we understand the Committee's need to develop legislative proposals in a timely manner. However, I would emphasize that CBO is still reviewing its projections and their underlying assumptions.

For 2003, CBO's preliminary projections suggest that, on average, a Medicare beneficiary will incur more than $2,400 in spending for prescription drugs used on an outpatient basis (see Table 4). The median value, a more representative measure of what most people spend, will be nearly $1,500 per person that year.

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4. CBO estimates that about 14 percent of Medicare beneficiaries obtained drug coverage through health maintenance organizations, primarily Medicare+Choice plans. And over 4 percent of Medicare beneficiaries received some drug coverage through other public programs, such as state pharmacy assistance programs or benefits through the Department of Veterans Affairs. All estimates of coverage are based on CBO's analysis of the Medicare Current Beneficiary Survey Cost and Use files for 1999.

Even without a Medicare prescription drug benefit, CBO expects average spending for prescription drugs to grow rapidly—at an average annual rate of about 10 percent per beneficiary—over the 2003-2012 period. That rate is considerably faster than the rate of growth projected for the combined costs of Medicare's Hospital Insurance and Supplementary Medical Insurance programs (Parts A and B) and for the nation's economy. However, that rate is also significantly lower than recent rates of growth: the Centers for Medicare and Medicaid Services estimates that spending per person for prescription drugs, averaged among everyone in the United States, grew by nearly 14 percent annually between 1995 and 2000 and peaked at more than 18 percent in 1999. Some of the slowdown in growth is associated with brand-name drugs whose patents will expire between now and the middle of the decade; some of it arises as well from a decline in the number of new drugs in development.

Implications of CBO's Estimates for the Costs of a Medicare Prescription Drug Benefit

To get a sense of what a proposal for prescription drug coverage might cost, consider a benefit that covered purchases of drugs only after an enrollee spent more than a deductible amount of $3,000. CBO's preliminary estimates suggest that in 2005, about a third of Medicare beneficiaries will spend $3,000 or more purchasing prescription drugs. Spending at or above that level would equal $52 billion, or about 41 percent, of a total of $128 billion in prescription drug expenditures that year (see Table 5). If the Medicare program subsidized 50 percent of beneficiaries' prescription drug spending at or above the $3,000 level, its costs for that benefit would total roughly $26 billion that year, with enrollees paying the remaining $26 billion through premiums, cost sharing, and payments by other insurers. (Enrollees and their non-Medicare insurers would also be responsible for covering the first $76 billion in prescription drug spending—that is, the costs of their purchases before reaching the $3,000 deductible amount.)

Although that example indicates the magnitude of Medicare's spending for such a benefit, it ignores some potentially large costs, such as subsidies to cover the federal share of premiums and cost sharing for low-income enrollees as well as the costs of creating and administering the new benefit. Moreover, most proposals for prescription drug coverage have had much more complicated structures—with lower deductibles to encourage broader enrollment and often caps on benefits to constrain costs to the Medicare program—than does the structure described in this example of a traditional insurance arrangement.

My presentation of CBO's estimates of prescription drug spending at today's hearing does not signal that CBO is fully prepared to score new proposals immediately. We are now "benchmarking" our models, in part by updating our estimates for some of the options developed in the 106th Congress. As part of that process, CBO is reviewing assumptions that were incorporated in earlier cost estimates in the light of more recent data and developments in the market for prescription drugs. We expect to be ready to provide briefings on the updated estimates and assumptions within a month.

The changes to CBO's baseline projections—to incorporate higher drug spending per capita and a new high-cost year in the projection window—imply that the price tags on proposals for a prescription drug benefit will be bigger today than they were last year. Exactly how much more costly is difficult to say, but recent experience may offer some guidance. Last year, CBO's baseline projection for total drug spending over the 2002-2011 period was 33 percent higher than the preceding projection as a result of the shift in the budget window and increases in estimates of prescription drug spending per person. Although that growth of 33 percent affected all proposals, the increase in costs for any specific option depended on the structure of its benefit package. For some of the proposals that CBO updated last year, the increase in costs of the Medicare drug benefit was considerably higher than the percentage increase in the baseline projection.

In updating its estimate of a proposal, CBO uses the same nominal values for deductibles, benefit limits, and stop-loss amounts (the cap on beneficiaries' out-of-pocket spending) that it used in estimating costs when the proposal was introduced.[5] Keeping those nominal features the same when drug spending is growing makes a bill's deductibles and stop-loss amounts relatively more generous. In contrast, for proposals that cap Medicare's drug benefit at a fixed dollar amount, keeping the same value for that limit would make the proposal relatively less generous as drug spending grew.

Under the nominal-dollar approach, some proposals introduced in the past would now be considerably more generous than they were when introduced—which means that the federal government would subsidize more of enrollees' prescription drug spending. For some proposals, a higher share of covered benefits would also translate into higher rates of enrollment, which would lead to even larger costs for the Medicare program.

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5. For example, if a proposal called for a deductible of $250 and a stop-loss amount of $5,000 beginning in 2004, CBO would use those same values of $250 and $5,000 but assume that the benefit would start in 2005.

Although this year's updated estimates of similar proposals will undoubtedly be higher than last year's estimates, they will not necessarily be 21 percent higher. Indeed, CBO's updated cost estimates could reflect higher rates of growth than the growth in baseline spending, depending on the structure of the proposals' benefits.

Patterns of Spending for Drugs and Other Health Services

The distribution of drug spending for Medicare beneficiaries is skewed: although nearly 90 percent of Medicare beneficiaries use some prescription drugs, the bulk of the population's drug spending is concentrated among a smaller group of individuals. For example, CBO projects that by 2005—the first year in which Medicare could probably begin to implement a new benefit—17 percent of enrollees will account for 55 percent of total drug spending by the Medicare population. Moreover, the annual spending of an individual enrollee among that 17 percent is likely to exceed $5,000. About 25 percent of Medicare beneficiaries are expected to have spending of $500 or less. Spending by those beneficiaries would make up just 1 percent of total prescription drug spending.

Yet even with that degree of asymmetry, spending for Medicare beneficiaries' outpatient prescription drugs is less concentrated than is spending for benefits that are already covered by the Medicare program. For example, the 10 percent of beneficiaries who have the highest spending for prescription drugs account for 40 percent of all outpatient prescription drug spending, whereas the 10 percent of beneficiaries who have the highest spending for the combination of services covered by Parts A and B of the program account for 65 percent of all Medicare spending.

Another characteristic of beneficiaries' prescription drug spending is that much of it is related to chronic health conditions, which often call for long-term drug therapies.[6] One implication of the association between chronic conditions and drug spending is that people with the very highest spending for drugs are likely to continue to have high spending in the future.[7]

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6. One study of prescription drug use among an insured senior population found that the top 10 categories of therapies ranked by number of prescriptions per person per year were for conditions that were primarily chronic in nature. Those therapies represented 55 percent of all claims. See Emily Cox and Catherine Roe, *Prescription Use Among a Commercially Insured Senior Population, 1998* (St. Louis: Express Scripts, Inc., May 2001).

7. A study of the drug spending of people age 65 or older found that those with the highest costs tended to use drugs from multiple therapeutic classes, suggesting the presence of several chronic conditions. See Cindy Thomas, Grant Ritter, and Stanley Wallack, "Growth in Prescription Drug Spending Among Insured Elders," *Health Affairs*, vol. 20, no. 5 (September/October 2001).

In comparison with spending for prescription drugs, spending for some services now covered by Medicare is much more variable for individuals over time—particularly expenditures for services related to hospitalizations and stays in other facilities. Even though many hospital admissions are ultimately related to an individual's chronic conditions, anticipating the timing of any one person's use of inpatient services is difficult. Nevertheless, there may be a certain proportion of Medicare beneficiaries—probably those with chronic conditions—who have high expenditures and who account for a large share of Medicare spending consistently from year to year.

More analysis is needed to understand the relationship between the use of outpatient drugs and spending for Medicare benefits. That relationship may vary by disease, by type of benefit, or by patient characteristic. However, for some beneficiaries who are very ill, one would expect spending for all types of health care services to be high. For others, the relationship may not be as clear.

CBO is analyzing the distribution of costs for Medicare services among beneficiaries in an effort to identify trends in spending and the characteristics associated with high levels of expenditures. What is now known is that, not surprisingly, Medicare beneficiaries who generate high costs for the program are very sick people, and a significant fraction of them die during or soon after the spell of illness that prompts those expenditures. But over half of the beneficiaries with high levels of expenditures survive, and some of them continue to generate high costs in succeeding years. Some of the goals of CBO's analysis are to identify beneficiaries with high costs for currently covered Medicare services, determine whether there is a percentage of the population that consistently generates high costs, distinguish the clinical characteristics of that population, and assess whether high-cost individuals can be identified.

Providing a Medicare Drug Benefit

Thus far, the debate over providing a prescription drug benefit under Medicare has focused on two general approaches: offering coverage to all Medicare beneficiaries or targeting coverage toward people with low income. However, other approaches are also available, although some have received less attention during the debate. Some policymakers advocate expanding Medicare benefits as part of a broader reform of the Medicare program. The organization and financing of health care have changed substantially since Medicare was established, and many private and public plans typically offer broader and more flexible packages of benefits. Medicaid has also moved toward offering broader coverage and flexibility to states in the structuring and administration of their programs.

An alternative approach is to target a Medicare drug benefit toward enrollees with specific clinical conditions rather than particular economic circumstances. For example, an integrated package of Medicare benefits could be developed that included a strategy for coordinating care and prescription drugs to help manage patients with certain diseases or chronic conditions. Along those lines, the Centers for Medicare and Medicaid Services recently announced a three-year demonstration project mandated by the Congress under which several disease-management organizations will develop approaches for managing patients with advanced-stage congestive heart failure, diabetes, and coronary heart disease. The announcement of the initiative noted that the demonstration will include coverage of prescription drugs for participating beneficiaries.

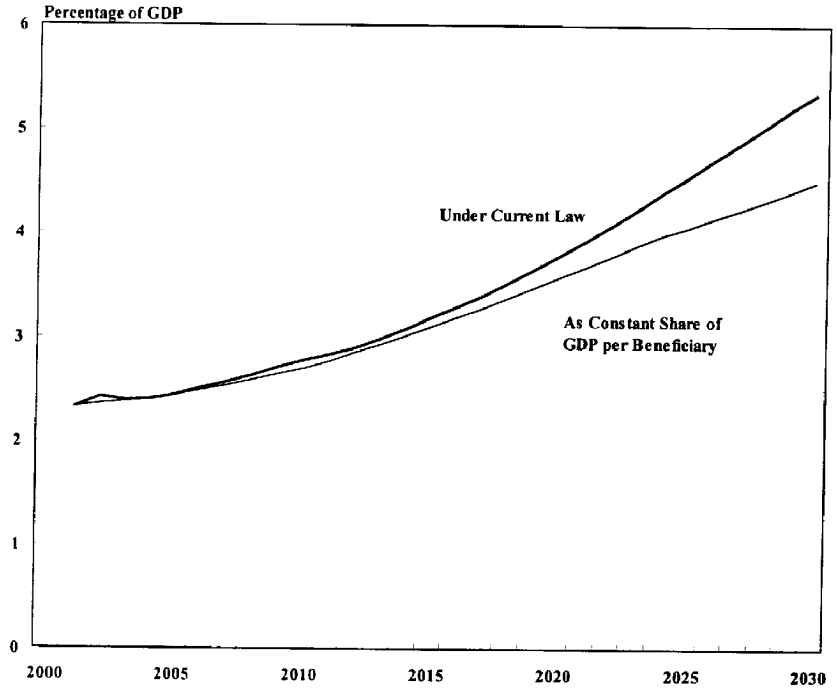
CONCLUSION

CBO's March baseline projection of $3.2 trillion in net mandatory spending for Medicare over the 2003-2012 period is about $80 billion, or 2.5 percent, lower than the projection released in January. Nevertheless, CBO's current projection and that of the Administration reflect underlying forces that will lead to faster growth in Medicare spending than in the economy as a whole. Some of those forces are the increases in payments to providers, which are linked automatically to changes in the prices of inputs; the rising volume of services being provided and changes in the mix of services toward those that are more technologically advanced and, in general, more costly; and increases in enrollment in the Medicare program.

Those factors contribute to the upward pressure on spending that is inherent in the Medicare program's structure under current law, and proposals to increase payments for certain providers would intensify that pressure. But the effects of those forces are overwhelmed by the dramatic growth of spending projected to begin at the end of this decade, as the baby-boom generation starts to become eligible for Medicare.

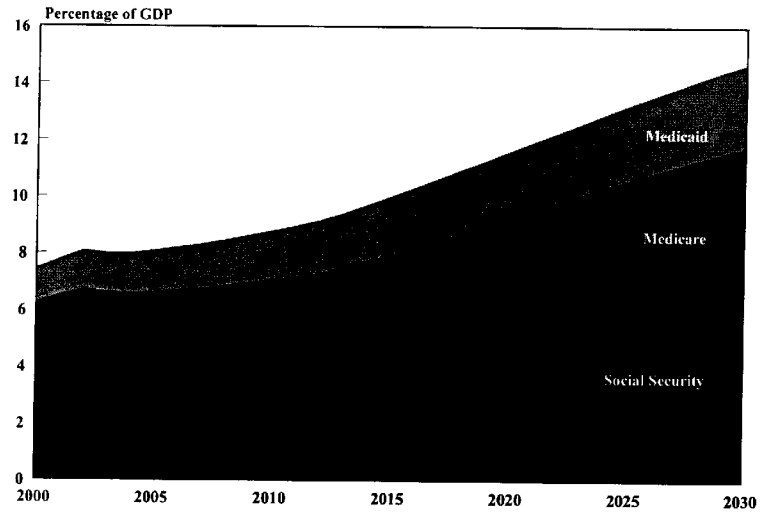
CBO's preliminary estimates suggest that spending for outpatient prescription drugs for the Medicare population will total $1.8 trillion between 2003 and 2012. That amount is 21 percent larger than last year's 10-year total, primarily because of the addition of a high-cost year (2012) and the loss of a low-cost one (2002). If the Medicare program subsidized a significant portion of beneficiaries' total drug expenditures, federal spending would jump. Moreover, CBO projects that over the 2003-2012 period, per-person spending for prescription drugs will grow at rates of more than 10 percent annually. Thus, without other changes to Medicare's benefits or the way in which the program is financed, adding a comprehensive prescription drug benefit would add significantly to the program's future budgetary pressures.

FIGURE 1. PROJECTED MEDICARE SPENDING UNDER ALTERNATIVE ASSUMPTIONS, 2001-2030



SOURCE: Congressional Budget Office.

FIGURE 2. SPENDING FOR SOCIAL SECURITY, MEDICARE, AND MEDICAID, 2000-2030



SOURCE: Congressional Budget Office based on its midrange assumptions about growth of gross domestic product and program spending. For further details, see Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2003-2012* (January 2002), Chapter 6.

TABLE 1. CBO'S MARCH 2002 BASELINE PROJECTIONS OF MANDATORY OUTLAYS FOR MEDICARE, 2002-2012 (In billions of dollars)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total, 2003-2012
Part A: Hospital Insurance												
Fee-for-service program												
Hospital inpatient care	102	108	115	122	130	138	147	156	166	176	188	1,445
Hospice	4	4	4	5	5	6	6	6	7	7	8	59
Skilled nursing facilities	14	14	15	17	19	21	23	25	27	30	33	224
Home health services	6	6	6	7	9	10	12	13	15	17	19	115
Subtotal	126	132	141	151	162	174	187	201	215	231	248	1,843
Group plans[a]	18	18	17	18	15	17	17	18	18	21	19	177
Total, Part A Benefits	144	150	158	169	177	191	204	218	234	252	267	2,020
Part B: Supplementary Medical Insurance												
Fee-for-service program												
Physician fee schedule	43	44	44	46	49	52	56	60	64	68	72	556
Other professional and outpatient ancillary services[b]	19	21	23	26	29	32	35	38	42	46	50	341
Other facilities[c]	21	22	24	27	29	32	36	39	43	46	51	350
Home health services	6	7	8	10	11	13	15	17	20	23	26	149
Subtotal	88	94	100	108	118	129	142	155	168	183	199	1,396
Group plans[a]	15	16	15	16	13	15	15	16	17	19	17	159
Total, Part B Benefits	103	109	115	124	131	144	157	171	185	202	216	1,555
All Medicare Benefits	247	259	273	293	309	335	361	389	419	454	483	3,575
Other Mandatory Outlays	2	2	2	1	2	2	1	2	2	1	2	15
Gross Mandatory Outlays	248	261	274	294	310	336	363	391	420	456	484	3,590
Premiums	-26	-28	-30	-32	-35	-39	-42	-46	-50	-54	-58	-413
Net Mandatory Outlays	223	233	245	262	275	298	321	345	371	402	426	3,177
Memorandum:												
All Home Health Agencies	11	12	14	17	20	23	27	31	35	40	45	264
All Group Plans	33	34	31	33	28	32	32	34	35	41	36	336
All Fee-for Service Programs	214	225	241	260	280	303	329	355	384	414	447	3,238
Net Outlays as a Percentage of GDP	2.2	2.1	2.1	2.2	2.1	2.2	2.3	2.3	2.4	2.4	2.5	n.a.

SOURCE: Congressional Budget Office.

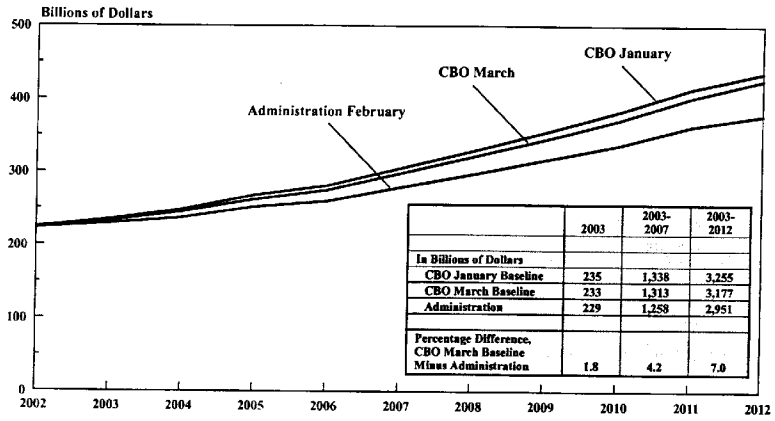
NOTE: Numbers may not add up to totals because of rounding.

a. Group plans include Medicare+Choice plans, plans paid on a cost basis, health care prepayment plans, and some demonstrations. Nearly all enrollment and spending is in Medicare+Choice plans.

b. Includes durable medical equipment, independent and physician in-office laboratory services, ambulance services, and other services paid by carriers.

c. Includes hospital outpatient services, laboratory services in hospital outpatient departments, rural health clinic services, outpatient dialysis, and other services paid by fiscal intermediaries. Also includes payments to skilled nursing facilities for services covered under Part B.

FIGURE 3. CBO'S AND THE ADMINISTRATION'S BASELINE PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE, 2002-2012



	2003	2003-2007	2003-2012
In Billions of Dollars			
CBO January Baseline	235	1,338	3,255
CBO March Baseline	233	1,313	3,177
Administration	229	1,258	2,951
Percentage Difference, CBO March Baseline Minus Administration	1.8	4.2	7.0

SOURCE: Congressional Budget Office.

TABLE 2. COMPARISON OF CBO'S AND THE ADMINISTRATION'S BASELINE PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE, 2002-2012

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total, 2003-2012
Net Mandatory Outlays (Billions of dollars)												
CBO	223	233	245	262	275	298	321	345	371	402	426	3,177
Administration	223	229	237	252	260	279	297	317	337	363	378	2,951
Difference (CBO minus Administration)	0	4	7	10	15	19	23	28	34	39	48	226
Annual Percentage Change in Spending												
CBO		4.0	4.7	4.9	7.3	4.8	8.3	7.6	7.6	7.5	8.3	6.1	6.6[a]
Administration		4.0	2.8	3.6	6.4	3.2	7.3	6.4	6.6	6.4	7.8	4.2	5.4[b]

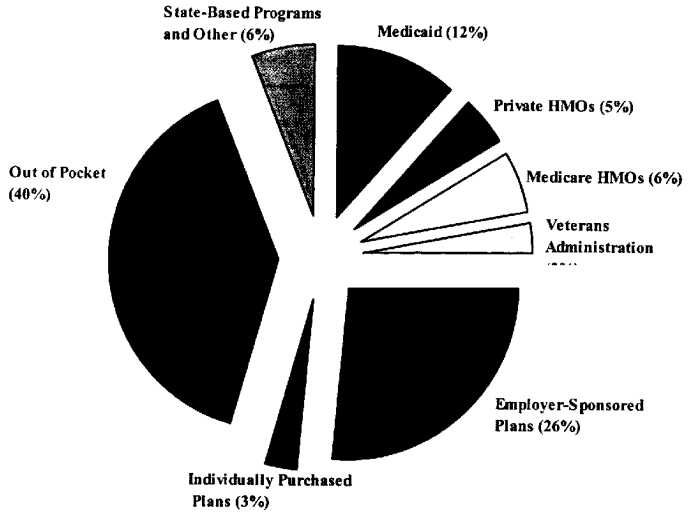
SOURCE: Congressional Budget Office.

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

a. Average annual rate adjusted to eliminate the effect of accelerating payments to group plans from October to September in some years.

b. Average annual rate.

FIGURE 4. DISTRIBUTION OF DRUG SPENDING FOR MEDICARE BENEFICIARIES, BY PAYER, IN 1999



SOURCE: Congressional Budget Office.

NOTE: HMOs = health maintenance organizations.

TABLE 3. COMPARISON OF CBO'S MARCH 2002 AND MAY 2001 BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING BY THE MEDICARE POPULATION (In billions of dollars)

Calendar Year	March 2002 Estimate	May 2001 Estimate
2002	87	81
2003	100	92
2004	113	104
2005	128	117
2006	143	131
2007	160	148
2008	179	166
2009	200	186
2010	222	208
2011	248	236
2012	278	n.a.
Total		
2002-2011	1,581	1,467
2003-2012	1,773	n.a.
Memorandum:		
Percentage Increase in Total Spending, March 2002 Estimates Over May 2001 Estimates, for 10 Years Ending in 2011		7.8
Percentage Increase in Total Spending, 10 Years Ending in 2012 (using March 2002 estimates) Over 10 Years Ending in 2011 (using May 2001 estimates)		20.8

SOURCE: Congressional Budget Office.

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

n.a. = not applicable.

TABLE 4. CBO'S BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING AND MEDICARE BENEFITS PER ENROLLEE, CALENDAR YEARS 2003-2012

	Spending per Enrollee (Dollars)		Average Annual Percentage Change, 2003-2012
	2003	2012	
Mean Drug Spending[a]	2,440	5,820	10.1
Median Drug Spending[b]	1,460	3,490	10.2
Medicare Benefits[c]	6,585	10,631	5.5
Memorandum:			
Gross Domestic Product per Capita	37,900	55,800	4.4

SOURCE: Congressional Budget Office.

a. Total spending per enrollee on outpatient prescription drugs not currently covered under Medicare, regardless of payer. Numbers based on CBO's March 2002 projections.

b. The median reflects the point at which half of all beneficiaries are projected to spend more than that amount and half are projected to spend less. Based on CBO's March 2002 projections.

c. Medicare benefits per enrollee under the Hospital Insurance and Supplementary Medical Insurance programs. Based on CBO's March 2002 baseline projections.

TABLE 5. PROJECTED SPENDING ON PRESCRIPTION DRUGS BY OR FOR MEDICARE ENROLLEES IN CALENDAR YEAR 2005

Spending Level per Enrollee (Dollars)	Spending At or Above the Level (Billions of dollars)	Share of Enrollees with Spending Above the Level (Percent)	Share of Total Drug Spending Above the Level (Percent)
0	128.1	89.8	100.0
500	110.0	75.1	85.9
1,000	94.7	64.4	73.9
2,000	70.2	47.4	54.8
3,000	52.4	33.7	40.9
4,000	39.7	24.5	31.0
5,000	30.5	17.3	23.8
6,000	24.1	12.4	18.8
7,000	19.3	9.3	15.1
8,000	15.8	6.9	12.3
9,000	13.1	5.5	10.2
10,000	10.9	4.3	8.5

SOURCE: Congressional Budget Office.

NOTES: Numbers are based on CBO's March 2002 projections.

Total Medicare enrollment for 2005 is projected to be 41.9 million people.

APPENDIX A: SOURCES OF VARIATION BETWEEN CBO'S AND THE ADMINISTRATION'S MEDICARE BASELINES

The Congressional Budget Office's (CBO's) and the Administration's projections of Medicare spending differ by about $225 billion over the 2003-2012 period. That difference stems from divergences in the assumptions underlying those estimates.

Differences Arising from Economic Assumptions

About $40 billion of the 10-year difference between CBO's and the Administration's estimates results from differing economic projections. Payment rates for most services are adjusted, or updated, each year to reflect changes in the prices of inputs. In general, CBO projects that those updates to payment rates will be 0.1 or 0.2 percentage points higher than the Administration's projected updates.

Differences Resulting from Assumptions About Administrative Actions

Another $10 billion to $20 billion of the 10-year difference stems from possible administrative actions that the Administration's baseline takes account of but that CBO's does not. The Administration's baseline incorporates the assumption that the payment method for outpatient prescription drugs covered under the Medicare program will change in 2003. However, the Administration has not yet put forward a specific proposal for changing the payment rules. As a result, CBO's projections incorporate the assumption that Medicare continues to use the existing payment method.

Differences Stemming from Technical Assumptions

The remaining difference of about $175 billion over 10 years reflects different technical assumptions about enrollment in Medicare+Choice plans and in the rate of increase in the volume and mix of services provided to beneficiaries in the fee-for-service sector. A clear comparison of CBO's and the Administration's baselines by payment category is difficult, because the two groups of estimates reflect very different assumptions about the proportion of beneficiaries who will participate in Medicare+Choice plans.

Assumptions About Medicare+Choice. The Administration projects that the proportion of beneficiaries enrolled in Medicare+Choice plans will remain fairly stable (in the range of 14 percent to 15 percent) over the coming decade, whereas CBO projects a sharp decline in that share (to 8 percent) by 2012. The Administration's assumption that a relatively large share of Medicare enrollees will remain in Medicare+Choice plans while the plans' payment rates are growing much more slowly than rates in the fee-for-

service sector may contribute significantly to the differences between CBO's and the Administration's baseline projections of Medicare spending.

Assumptions About Growth Stemming from the Volume and Mix of Services in the Fee-for-Service Sector. The projections of both CBO and the Administration incorporate the assumption that spending per capita for services in the fee-for-service sector of Medicare will grow at a faster rate than will the adjustments to payment rates for changes in input prices. In general, however, CBO projects larger increases in per capita spending as a result of changes in the volume and mix of services than the Administration does.

Those assumptions about spending increases differ the most for the areas of skilled nursing services, hospital outpatient services, and home health services. The payment systems in all three settings have changed substantially in the past few years, and whether and how the volume and mix of services will change under the new systems is uncertain. Both CBO and the Administration assume that increases in the volume and changes in the mix of those services will contribute less to growth in spending under current law than they contributed under the payment systems that existed before the Balanced Budget Act of 1997 was enacted. CBO estimates that the contributions to growth made by volume and mix changes will steadily decline over the coming decade as follows:

- For skilled nursing services, dropping from about 7 percentage points a year in the next few years to 4.5 percentage points by 2012;
- For hospital outpatient services and other payments to facilities for services covered under Part B of Medicare, falling from about 5.3 percentage points annually to 3.8 percentage points; and
- For home health services, declining from 12.5 percentage points to 7 percentage points a year.

The Administration appears to make a similar assumption about the steadily lessening effect of changes in the volume and mix of services—although it projects a more rapid decline than does CBO—for skilled nursing services and hospital outpatient services. Compared with CBO's assumption about the effects of volume and mix changes for home health services, however, the Administration's assumption seems to reflect more-rapid increases in the effects of volume and mix changes for home health services through 2005 or 2006 and a more rapid decline in subsequent years.

CBO and the Administration make very similar assumptions about the effects of volume and mix changes in relation to the sustainable growth rate (SGR) system of payment for

services on the physician fee schedule and in relation to payments to hospitals for inpatient services.

The SGR system automatically adjusts payment rates for services on the schedule to compensate for changes in the volume and mix of services. Therefore, the differences between CBO's projections of payments under the physician fee schedule and the Administration's projections are almost entirely attributable to economic factors and to differences in the projected number of beneficiaries in the fee-for-service sector. Likewise, both CBO and the Administration assume that changes in the mix and volume of services contribute about 1 percentage point to annual increases in payments to hospitals for inpatient services—1 percentage point, that is, above the growth resulting from increases in enrollment and adjustments for inflation.

APPENDIX B: CBO'S ASSUMPTIONS FOR ITS ESTIMATE OF THE ADMINISTRATION'S PRESCRIPTION DRUG PROPOSAL

In developing estimates of the costs of the President's recent proposal for prescription drug coverage, the Administration and the Congressional Budget Office (CBO) used different assumptions for three factors: which states would participate by offering coverage, how many eligible beneficiaries would enroll for the benefit, and the level of spending per enrollee.

Participation by States

CBO anticipated that certain states would be more likely than others to provide coverage for prescription drugs under this proposal. First, states that have pharmacy assistance programs (23 at last count) would be more likely to participate because the proposal would allow them to receive federal matching funds for those programs, which are now entirely state-funded. Second, states whose Medicaid programs already cover all aged and disabled individuals below the poverty level would be more likely to participate than states that do not provide such coverage. For the states that already covered those low-income people, expanded coverage for prescription drugs would qualify for the higher federal matching rate of 90 percent and thus require relatively little additional state spending. At least 15 states fall into that category, and another four have eligibility limits that are just below the poverty level. In contrast, states with less generous Medicaid programs would have to expand eligibility significantly—and on average pay 43 percent of the resulting costs—before they would receive the 90 percent federal match.

Of the remaining states, CBO expects that a portion would participate and that they would be less likely than other states to expand coverage fully to 150 percent of the poverty level.

CBO assumed that about 65 percent of the population eligible for the proposed benefit would reside in participating states. The Administration assumed that about 70 percent of the eligible population would come from those states.

Participation by Beneficiaries

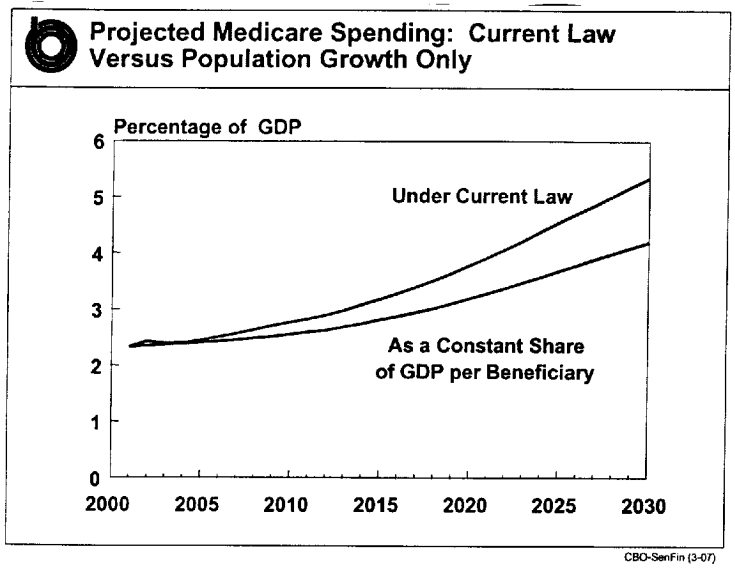
In developing its estimate, CBO also made an assumption about the level of participation of Medicare beneficiaries in states that decided to offer prescription drug coverage under the proposal. CBO assumed that almost 60 percent of eligible Medicare beneficiaries would ultimately participate, on the basis of experience with Medicaid and other low-income programs as well as the extent of employer-sponsored coverage among the eligible population. Thus, CBO estimated, the total number of participants in the

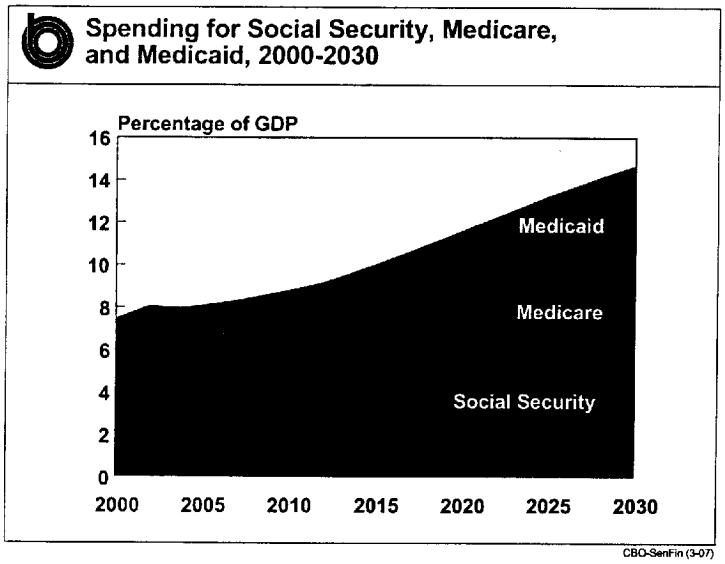
program would gradually rise from about 900,000 in 2003 to 2.4 million by 2007; participants would constitute about 6 percent of all Medicare beneficiaries and 18 percent of beneficiaries with income below 150 percent of the poverty level. By comparison, the Administration assumed that about 70 percent of eligible beneficiaries would participate. Those differing assumptions are the primary reason that CBO's estimate is lower than the Administration's.

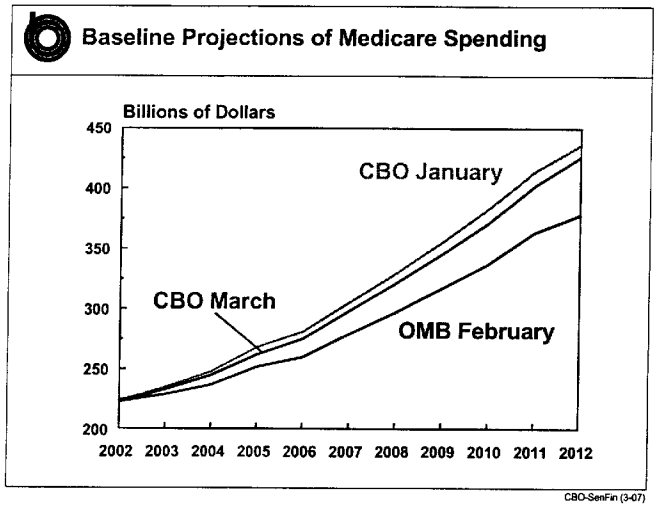
Per Capita Costs

Finally, CBO assumed that the generosity of the prescription drug benefits offered under the proposal would vary from state to state, ranging from the benefits provided by pharmacy assistance programs to those provided under employer-sponsored coverage. CBO also anticipated that the prescription drug benefits typically offered by the states would be less generous than those provided in existing state Medicaid programs. The Administration's estimate incorporated the assumption that the drug benefits provided under the proposal would equal average drug spending for the overall Medicare population, as calculated from the accounts maintained by the Centers for Medicare and Medicaid Services.

Charts Presented at the Hearing







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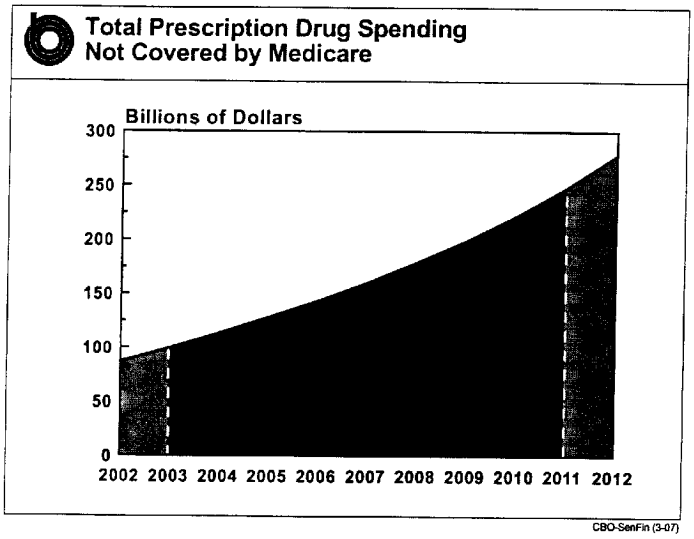
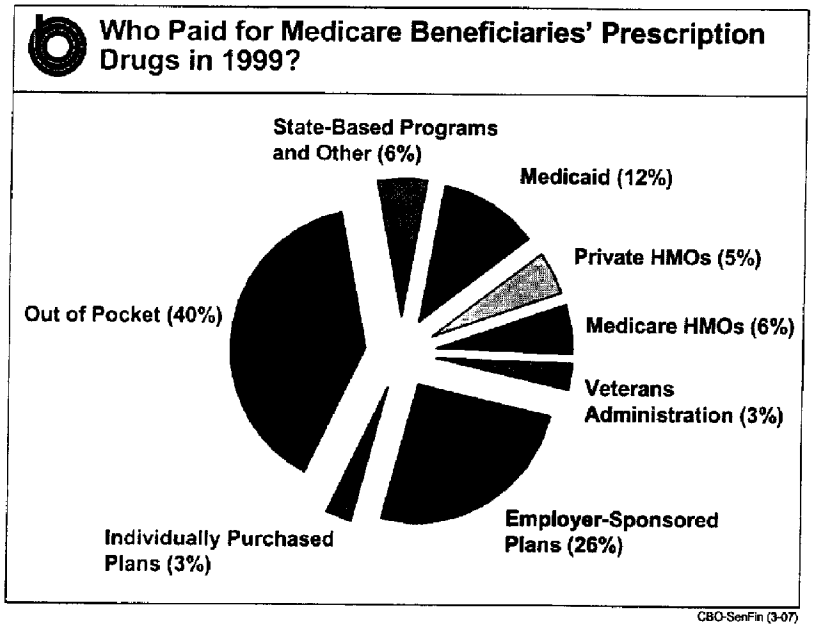
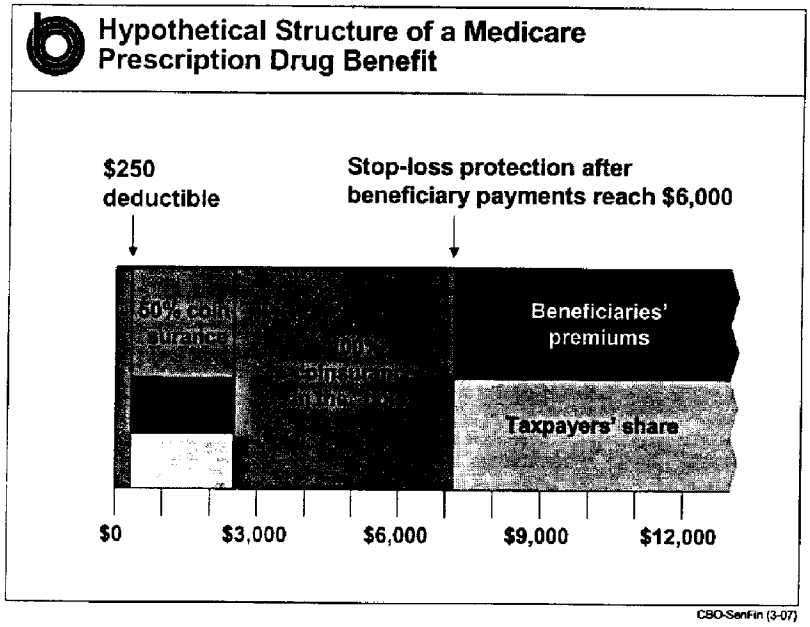
CBO-SenFin (3-07)

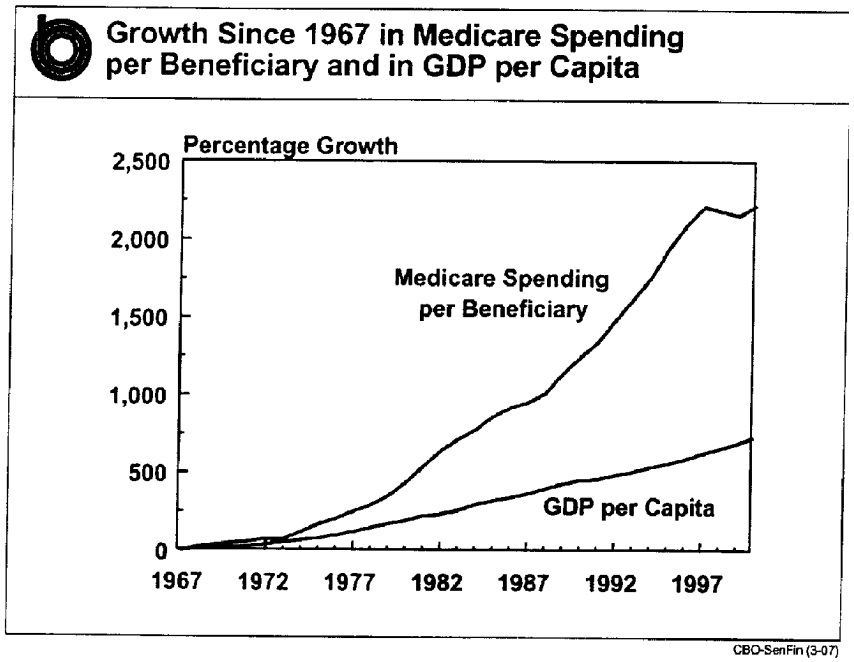


	2002	2012	Average Annual Change, 2003-2012
Spending per Capita (Dollars)	2,440	5,280	10.1%
			Cumulative, 2003-2012
Total Drug Spending (Billions of dollars)	100	278	1,773

CBO-SenFin (3-07)


Who Paid for Medicare Beneficiaries' Prescription Drugs in 1999?
State-Based Programs and Other (6%)
Medicaid (12%)
Private HMOs (5%)
Medicare HMOs (6%)
Veterans Administration (3%)
Employer-Sponsored Plans (26%)
Individually Purchased Plans (3%)
Out of Pocket (40%)
CBO-SenFin (3-07)


Hypothetical Structure of a Medicare Prescription Drug Benefit
$250 deductible
Stop-loss protection after beneficiary payments reach $6,000
Beneficiaries' premiums
Taxpayers' share
$0
$3,000
$6,000
$9,000
$12,000
CBO-SenFin (3-07)



RESPONSES TO QUESTIONS FROM SENATOR GRAHAM

Question 1: CBO has pointed to statements from Merck-Medco to justify its assumption that insurance companies would come to the table to offer a risk-based prescription drug benefit under Medicare. But recently, Merck-Medco announced that it plans to divest its PBM from its drug development and manufacturing business. And we just witnessed another round of Medicare+Choice plans exiting the program. Does CBO continue to assume that private insurers would choose to offer a drug benefit?

Answer: CBO developed its assumption about competitive risk-based prescription drug plans after discussions with a variety of experts, including representatives of pharmacy benefit managers (PBMs), insurance companies, and reinsurance companies. Thus, its analysis does not rest on Merck-Medco's statements about participation.

On the one hand, some PBMs and other entities have argued that they might not enter the market for providing a Medicare prescription drug benefit. PBMs are concerned that their current net operating profits are small relative to the losses they might incur, given the total drug spending likely in a large Medicare population. In general, PBMs are not currently structured in a way that would allow them to enter into risk-bearing arrangements. They lack both the capital and the licenses needed to bear risk.

On the other hand, reasons exist to think that private entities would participate in a Medicare drug benefit. Medicare is a large market, and plans that sat out the initial years of a benefit might find it hard to gain enrollment should they decide later to participate. In addition, plans with Medicare offerings would have an advantage in contracting with private employers, who would prefer to coordinate benefits for their covered retirees.

Although PBMs do not now typically bear the risk of losses, they could partner with insurers who take on and manage risk. They and their partners could also purchase reinsurance to limit their risk. However they chose to manage it—whether by purchasing reinsurance or through their own efforts—CBO assumes that they would build the costs of both risk bearing and benefit management into the premium they intended to charge. Over time, as plans gained experience in administering the drug

benefit, risk premiums would decline, CBO believes, especially for plans that succeeded in their risk-management efforts.

Certain features of some of the proposals introduced last year encourage plans to bear risk in a competitive system. Those features include:

- One-time enrollment for beneficiaries, including penalties associated with entering the program later—which would prevent people from taking advantage of the benefit only when they expected to spend a large amount on prescription drugs.
- Government subsidization of the benefit, including subsidies for low-income people—which would further broaden the pool of beneficiaries enrolled in the program.
- Reinsurance through the federal government or some other mechanism to limit plans' total spending for high-cost enrollees—which would partially insulate plans from the highest levels of risk.

Thus, CBO's assessment that private entities would compete in providing an at-risk Medicare drug benefit was not conditioned on Merck-Medco's assertion that it would participate nor on Medco's association with Merck.

Question 2: As you know, there is great interest in encouraging the use and availability of generic drugs. There are also additional cost- containment measures we could consider—addressing the explosion of direct-to-consumer advertising, price disclosure, modifications to AWP, and efforts to reduce medication errors, to name a few. Has CBO arrived at any conclusions as to the effect of these types of measures?

Answer: Spending on prescription drugs has been the fastest-growing component of health care costs for a number of years. CBO projects that per capita drug spending by or on behalf of Medicare beneficiaries, while slowing from recent peak levels, will continue to grow quickly. Indeed, per capita spending on outpatient prescription drugs used by Medicare beneficiaries is expected to grow at an average annual rate of 10.1 percent over the next 10 years. Between 2003 and 2012, CBO estimates that annual drug spending for the average Medicare beneficiary will grow from $2,440 to $5,620. Spending on outpatient prescription drugs used by Medicare beneficiaries as a share of gross domestic product (GDP) will double—rising from 0.8 percent to 1.6 percent—during the 10-year period.

Shifting utilization from brand-name to generic drugs should reduce spending, but the amount of the reduction is unclear. Although generic drugs account for between 40 percent and 45 percent of prescriptions written for Medicare beneficiaries, they account for a much smaller share of drug spending because of their lower prices. Moreover, the U.S. system of patents and the new-drug rules of the Food and Drug Administration provide strong intellectual property protections for innovator drugs. Granting those protections creates a monopoly for a period of time, which skews the operation of the normal rules of supply and demand.

How the various mechanisms listed in the question would affect the per capita cost of drugs depends critically on the other features included in a Medicare drug proposal. Unfortunately, in an area as complicated as prescription drugs, it is very difficult to generalize about the effects of specific provisions without knowing both their details and overall policy context.

Question 3: The Administration has proposed a discount card program, reasoning that implementation of such a program will facilitate implementation of a comprehensive prescription drug benefit. If the discount card program were put into place, either by legislation or regulation, what would CBO assume about the effects the discount card program on the implementation time line and costs of a comprehensive benefit?

Answer: CBO assumes that, in general, a new Medicare prescription drug benefit could be implemented about two years after it was enacted. (For example, a proposal enacted this year would become effective on January 1, 2005.) That may seem like a long lead time, but CBO believes that achieving such a schedule would in fact require an aggressive implementation plan.

As we understand the Administration's proposal, the presence of a card program would not materially alter the implementation schedule. That conclusion is based on several assumptions. A new benefit would begin in a new calendar year—on January 1st—rather than in the middle of the year. (The January 1st start date is an element common to all of the prescription drug proposals that CBO has reviewed.) Although having a prescription drug card program in existence might simplify some tasks, it would probably not reduce by a full year the time needed to implement a Medicare drug benefit. However, depending on the actual details of the Administration's proposal and when it was implemented, the implementation periods for a drug card program and a Medicare drug benefit might overlap, which presumably would make implementation of the Medicare drug benefit somewhat more complicated.

In general, CBO estimates that a drug card program would have no effect on the federal government's costs for a new Medicare drug benefit—even if the drug card program was shown to lower costs for prescription drugs. That possibly confusing conclusion stems from the fact that under current law, the overwhelming bulk of spending on prescription drugs for the elderly and disabled does not involve Medicare. Stated differently, there is no federal budget "baseline" for outpatient drug spending by Medicare beneficiaries because such spending takes place outside of Medicare—and the federal budget. In estimating the cost of a Medicare drug benefit, what matters are the projected federal outlays for the new program, not how they might change the (private-sector) baseline.

RESPONSES TO QUESTIONS FROM SENATOR LINCOLN

Question 1: Mr. Crippen, by now you and your staff have had a chance to evaluate the President's Medicare prescription drug and reform proposals. I'd like to hear more about CBO's assessment of the low- income proposal. How many states are currently in a position to take up the Administration's low-income coverage option? How many states does CBO believe will adopt the low-income benefit option?

Answer: CBO anticipates that certain states would be more likely than others to provide prescription drug coverage under the Administration's proposal.

- First, states that had pharmacy assistance programs (23, at last count) would be more likely to participate because the proposal would allow them to receive federal matching funds for those programs, which are now funded entirely by the states.
- Second, states whose Medicaid programs already covered all aged and disabled individuals below the poverty level would also be more likely to participate. In those states, expanded prescription drug coverage would qualify for the attractive 90 percent federal match and thus require relatively little additional state spending. At least 15 states fall into this category; another four have eligibility limits that are just below the poverty level. In contrast, states with less generous Medicaid programs would have to expand eligibility significantly—and, on average, pay 43 percent of the resulting costs—before they would receive the 90 percent federal match.
- CBO expects less participation among the remaining states than among states with programs for pharmacy assistance or low-income coverage. States without such programs would also be less likely to expand coverage fully to 150 percent of the poverty level.

CBO assumed that participating states would represent about 65 percent of the eligible population. The Administration, in comparison, assumed that participating states would ultimately reflect about 70 percent of the eligible population.

Question 2: Among the many prescription drug options that CBO has estimated, can you tell us more about the kind of drug benefit $190 billion would buy?

Answer: Without a specific benefit design, it is difficult to speak in terms of participation rates, premiums, and other issues. However, CBO estimates that $190 billion will cover between 10 percent and 15 percent of total spending on prescription drugs by or for the Medicare population from 2005 through 2012. Those figures incorporate the assumption that none of those funds would be devoted to a low-income subsidy program.

Question 3: As you know, a lot of the controversy surrounding prescription drugs has to do with the delivery model. Some of my colleagues support using private insurers to administer the benefit. Last year, and the year before, CBO pointed to statements from Merck-Medco to justify its assumption that insurance companies would come to the table to offer a risk-based prescription drug benefit under Medicare. But recently, Merck-Medco announced that it plans to divest its PBM from its drug development and manufacturing business. And we just witnessed another round of Medicare+Choice plans exiting the program. Does CBO continue to assume that private insurers would choose to offer a drug benefit?

Answer: CBO developed its assumption about competitive risk-based prescription drug plans after discussions with a variety of experts, including representatives of pharmacy benefit managers (PBMs), insurance companies, and reinsurance companies. Thus, its analysis does not rest on Merck-Medco's statements about participation.

On the one hand, some PBMs and other entities have argued that they might not enter the market for providing a Medicare prescription drug benefit. PBMs are concerned that their current net operating profits are small relative to the losses they might incur, given the total drug spending likely in a large Medicare population. In general, PBMs are not currently structured to enter into risk-bearing arrangements. They lack both the capital and the licenses needed to bear risk.

On the other hand, reasons exist to think that private entities would participate in a Medicare drug benefit. Medicare is a large market, and plans that sat out the initial years of a benefit might find it hard to gain enrollment should they decide later to participate. In addition, plans with Medicare offerings would have an advantage in contracting with private employers, who would prefer to coordinate benefits for their covered retirees.

Although PBMs do not now typically bear the risk of losses, they could partner with insurers who take on and manage risk. They and their partners could also purchase reinsurance to limit their risk. However they chose to manage it—whether by purchasing reinsurance or through their own efforts—CBO assumes that they would build the costs of both risk bearing and benefit management into the premium they intended to charge. Over time, as plans gained experience in administering the drug benefit, risk premiums would decline, CBO believes, especially for plans that succeeded in their risk-management efforts.

Certain features of some of the proposals introduced last year encourage plans to bear risk in a competitive system. Those features include:

- One-time enrollment for beneficiaries, including penalties associated with entering the program later—which would prevent people from taking advantage of the benefit only when they expected to spend a large amount on prescription drugs.
- Government subsidization of the benefit, including subsidies for low-income people—which would further broaden the pool of beneficiaries enrolled in the program.
- Reinsurance through the federal government or some other mechanism to limit plans' total spending for high-cost enrollees—which would partially insulate plans from the highest levels of risk.

Thus, CBO's assessment that private entities would compete in providing an at-risk Medicare drug benefit was not conditioned on Merck-Medco's assertion that it would participate nor on Medco's association with Merck.

Question 4: I believe I've heard you say at one point that private insurers are more efficient at controlling drug spending than entities that bear risk only for administrative costs. However, private insurers will demand a higher profit margin or "risk load" that would offset much of these savings. An analysis by CBO last year assumed that private insurers would save only about 2 percent more than PBMs in delivering a drug benefit. Thus, when we compare the actual net effects of PBMs compared to private insurers, the savings are really not all that significant, wouldn't you say?

Answer: CBO estimates that, in general, for any given benefit structure, costs per beneficiary will be lower for delivery models with private plans that both compete for beneficiaries' business and take on insurance risk than for models that depend on a single PBM administrator. However, costs in the form of marketing expenses will be higher for models with competing delivery systems, as will costs for risk premiums among delivery models that feature risk-bearing plans. (The risk premium represents the extra return on investment that competing at-risk plans would require to enter the market and the cost to an entity of buying reinsurance.)

- CBO also believes that both marketing and risk premium costs, measured as a percentage of drug spending, will be highest in the early years of the prescription drug program, reflecting start-up expenses and some uncertainty about how much it will cost to provide the benefit. Over time, CBO expects that marketing costs will be relatively fixed and the risk premium will fall to a steady state. Thus, the relationship changes between the savings to be gained from a delivery system that includes risk-bearing plans and the costs for marketing and administration (known as the "load"): such costs initially outweigh savings, but then savings grow over time to overtake them.

CBO has estimated savings for two recent proposals after netting out the risk premium and the load. By 2012, the Breaux-Frist bill, with its competing at-risk plans, would deliver net savings equal to 15 percent of benefit costs, CBO estimates. The Robb amendment, which calls for plans to compete but not bear insurance risk, would save about 13 percent.

A difference of 2 to 3 percentage points in savings can represent a substantial amount in the context of proposals that would cost hundreds of billions of dollars over a 10-year period. But other factors must also be considered. The Robb amendment proposed a much richer benefit structure than did the Breaux-Frist bill; consequently, savings of 13 percent on a higher-cost benefit package can appear larger than savings of 15 percent on a less comprehensive package. To fully appreciate how important the delivery model is to the costs of a drug benefit over 10 years would

require comparing two proposals with the same benefit structure but different delivery models.

PREPARED STATEMENT OF HON. CHARLES E. GRASSLEY

Let me preface my comments by noting that I was pleased to learn from Director Crippen's testimony that Medicare spending is now projected to be $80 billion lower over the coming decade than was previously projected. As far as I'm concerned, that money should be spent on Medicare beneficiaries, not for other purposes.

I applaud President Bush for his commitment to making Medicare better serve beneficiaries. The biggest flaw in Medicare today is its failure to cover prescription drugs. The President highlighted this during his campaign, and he's continued to reach out to Congress, seeking to work together. It should come as no surprise to anyone who knows this President that he is standing by the commitments he made on the campaign trail.

In terms of congressional action on a drug benefit, several crucial developments are coming up in the next month or so. The first is the budget process. Last year, I was pleased to work with Senator Snowe to create a $300 billion reserve fund to improve Medicare, including adding drug coverage. Whether both houses of Congress will be able to agree on a budget resolution by the April 15 deadline this year is an open question; I certainly hope so. But if we're not, then that $300 billion figure will remain in force. So that number may continue to be a very important one. We'll know more on April 15.

Another critical factor in the next month will be the Congressional Budget Office's input on the costs of prescription drug proposals. Today, Director Crippen is starting this process by presenting CBO's new projection of drug spending. In the following weeks, CBO will be re-estimating existing proposals, which will set the stage for scoring new ones. Between this effort and the budget process, it will begin to become clear in April what parameters this committee will need to work within.

Now, as you know, a group of us on the Finance Committee are working to develop a comprehensive bill to strengthen and improve Medicare, including adding a prescription drug benefit that is affordable to beneficiaries, and affordable to our nation. I appreciate Senator Kerrey's reminder of the big picture of Medicare and the federal budget as a whole; to focus on the drug benefit in isolation would be an irresponsible luxury—one we can't afford.

Director Crippen's testimony reminds us that drug costs are growing explosively, and that we must make sure any benefit is delivered in the most cost-efficient, competitive manner. We owe it to all Americans to make sure there's no waste in a new Medicare drug benefit.

Another thing we must do is ensure that the drug benefit works just as well for beneficiaries in rural America as it does for others. Rural seniors cannot afford for us to repeat the mistakes of the past, with payments or delivery systems that discriminate against low-cost areas. My bill will definitely be one that works for rural America. And by the way, while the existing Medicare fee-for-service system is not the focus of this hearing, I want to make it clear that I'll be fighting for more equity in Medicare payments this year. For the people I represent, that's just as much a part of strengthening and improving Medicare as adding a drug benefit.

Will we achieve a comprehensive new drug benefit this year? There will always be a temptation to let the best be the enemy of the good. Some say that proposals to spend sums of money that are obviously unsustainable, in the larger context of Medicare and the budget as a whole, have been a death knell to the chances of getting a drug benefit done. Well, I think the key to finding agreement is to meet in the middle. Let's do that and see what we can get done.

PREPARED STATEMENT OF BOBBY P. JINDAL

Chairman Baucus, Senator Grassley, distinguished Committee members, I am pleased to be here this morning to discuss the President's approach to strengthening Medicare. Administrator Scully has submitted his statement for the record but he asked me to join him so that I could summarize the Administration's overall vision for an improved Medicare program. Tom will then discuss a number of the initiatives that he has been spearheading to provide immediate help to seniors with their drug costs and other options. We believe these immediate steps should be integrated into Medicare legislation both for their own sake and because they will pave the way for a full prescription drug benefit and the other improvements that Medicare needs.

This committee obviously played a key role in creating the Medicare program. When that legislation was enacted, President Johnson said: "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime." Thirty-six years later, President Bush believes it is time for our Nation to come together and renew that commitment. Secretary Thompson, Tom, and I share the President's view that we have a moral obligation to fulfill Medicare's promise of health care security for America's seniors and people with disabilities.

Medicare has provided this security to millions of Americans since 1965. But its lack of prescription drug coverage demonstrates that Medicare is not keeping up with the rapid advances in medical care. Looking ahead, medical care holds the promise of improving and extending life through countless innovations. But as we enter the 21st century, Medicare's promise is threatened by: outdated benefits; limited financial protection against high medical costs; a system that has not delivered reliable health plan options; and a traditional government plan that often fails to deliver responsive services to beneficiaries or ensure high-quality care.

The 77 million Americans who will be entitled to Medicare in 2030 are counting on Medicare's promised benefits. Yet even Medicare's current benefits are not secure for the retirement of the Baby Boom generation. Medicare's fund for hospital insurance will face cash flow deficits beginning in about 15 years and is projected to become insolvent within 30 years. Medicare's fund for its other benefits will require nearly a doubling of beneficiary premiums and infusions of general revenues to remain solvent over the next 10 years. Medicare's accounting disguises the true fiscal health of Medicare and makes it difficult to plan ahead.

Recognizing these problems, President Bush has worked with members of Congress from both parties to develop a framework for a modernized Medicare program and for keeping Medicare's benefits secure. The President's framework includes the following principles:

- All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.
- Modernized Medicare should provide better coverage for preventive care and serious illnesses.
- Today's beneficiaries and those approaching retirement should have the option of keeping the traditional Medicare plan with no changes.
- Medicare should provide better health insurance options, like those available to all Federal employees.
- Medicare legislation should strengthen the program's long-term financial security.
- The management of the government Medicare plan should be strengthened so that it can provide better care for seniors.
- Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.
- Medicare should encourage high-quality care for all seniors.

In his budget and State of the Union address, the President renewed his commitment to provide prescription drug coverage in Medicare and make other improvements, based on this framework for bipartisan legislation. The President's budget proposal included substantial added spending to improve Medicare. Looking ahead, we can surely will have a healthy debate about how much additional funding is necessary over the next decade to modernize Medicare and provide a prescription drug benefit—whether it's the $190 billion proposed by the Administration, the $300 billion level that had strong bipartisan support last year, or some other figure. It is important to recognize that we support a package of improvements to bring Medicare up to date—including reliable, less costly health care coverage options, an improved benefit package, and lower drug prices through competition.

Other may advocate a different approach, but we hope all can agree that scarce funds should not go merely to "crowd out" existing sources of drug coverage—including the employer coverage many seniors enjoy today. We also hope a consensus can be reached that the drug benefit should use the most effective means to get competitive price discounts for seniors and for Medicare. We must also ensure that the drug benefit enacted this year will be there for tomorrow's seniors as well as today's. And we should also be able to agree about more than the design of a drug benefit that—under any proposal—would not be implemented for several years. In particular:

- Medicare legislation should address the full range of shortcomings that Medicare faces, which include but are not limited to its lack of drug coverage, and
- Medicare legislation should also include steps to provide immediate assistance to seniors with their drug costs and other health care choices—so they do not have wait any longer even as we build the foundations for a full drug benefit.

Tom will discuss these immediate steps in a moment, but let me just conclude by stressing that we are committed to working constructively with Congress to enact legislation consistent with the President's principles—so that we can put a prescription drug benefit into place this year. We all know that failing to act to meet these unavoidable challenges may lead to more extreme changes later, including government controls on prescription drugs and stricter coverage limits in Medicare. These changes would reduce access to needed treatments and slow the development of new technologies, such as promising new drugs for common cancers and other diseases. Instead, we must come together now to take the sound, careful, and deliberate steps needed to improve the Medicare program for today's seniors and tomorrow's. And we must start this process now—these issues have been debated on and off for years, and now it is time for action. Thirty-six years from today, we should still have a Medicare program that fulfills President Johnson's promise of a secure and vibrant retirement.

PREPARED STATEMENT OF HON. BOB KERREY

Members of the Senate Finance Committee, my former colleagues: You have my sincere sympathy. As elected representatives of the people, you are regularly given two irreconcilable and at times unconditional demands: lower taxes and higher spending. A majority of Americans believe their taxes and government spending are too high. Simultaneously they don't want their military base closed, they don't want their highway project un-funded, they want smaller class sizes for their schools, and they want help paying for the cost of their prescription drugs. Which is what brings us together this morning.

You have invited me to testify on the question of adding a prescription drug benefit to Medicare. My simple advice is don't do it. Not unless you are prepared to make structural reforms in the Medicare program itself or better: An overhaul in the way we finance all of health care. Adding a prescription benefit to Medicare without fundamental reform will partially solve one problem while increasing the size of several others.

It will partially solve the problem of helping current Medicare beneficiaries pay for their prescriptions, but it will increase the size of the problem of declining shares of our federal budget available for spending on such things as education, child care, transportation, and technology. At best it does nothing to solve and at worse it increases the problem faced by non-Medicare eligible and uninsured working Americans. With budget caps gone, income taxes already cut, and bipartisan enthusiasm to spend considerably more on defense, it is safe to say that the brief era of surpluses is over.

Last year's Congressional Budget Resolution set aside $300 billion over 10 years for a Medicare prescription drug benefit. All things seemed possible at this time last year when both CBO and OMB were projecting a 10-year unified surplus of $5.6 trillion ($3.1 trillion on-budget and $2.5 trillion off-budget). This year any such initiative would have to be financed by borrowing from the public or from the Social Security surplus. And the assumption there will be future surpluses even counting Social Security is dubious if the following is true:

That most of last year's tax cut (along with several other popular tax provisions) will be extended rather than repealed at the end of 2010; that Congress will reduce the individual Alternative Minimum Tax as the number of people covered by this provision grows from 2 to 40 million far more than was ever intended; that defense and non-defense discretionary spending will grow faster than inflation.

Indeed, the Concord Coalition, of which I am co-chairman, has prepared an alternative baseline using CBO numbers showing what would happen if just two of these three occur: all expiring tax cuts are extended and discretionary spending keeps pace with GDP growth. This is far from a "Doomsday" scenario. In fact it seems more plausible than the official baseline. Under these circumstances the entire unified surplus is virtually eliminated. Stated differently: Payroll taxes in excess of costs for Social Security and Medicare, how being used to pay down debt, will be needed to pay for defense and non-defense spending.

The bottom line is that there is no room to add a major entitlement expansion such as a Medicare prescription drug benefit. Such an addition—as worthy as it absolutely is in isolation—would significantly impair the financial future of working men and women, the people who pay the bills. And their financial future has already deteriorated significantly in just one year.

Consider this: Last year Americans were looking at a future in which we were projected to eliminate the debt held by the public by 2008. Total debt limits would not be exceeded until 2009. Net interest payments over the period from 2002

through 2011 were estimated to be $622 billion. Today, we no longer forecast that public debt will be eliminated. The debt limit may be reached this month and net interest payments over the next ten year period will be one trillion dollars more than expected last year. That is $10,000 per American household or $1,000 per household per year.

What makes this gloomy picture of our financial future worse is that we still have not changed Federal laws to accommodate for the baby boom generation. From 2006 to 2026 the number of workers whose taxes support retirement benefits will increase from 160 million to 174 million while the number of Social Security and Medicare beneficiaries will increase from 49 to 78 million. Instead of being able to tax three to support one we will be taxing two to support one.

The details of what will happen were presented to Congress by the General Accounting Office in February. I regret to inform you that few of us outside Congress were paying much attention to what GAO said and were still suffering the illusion that Medicare's future still was bright. We had been focused on the improvement in the HI Trust fund's shorter-range solvency status and missed that Medicare's long-term outlook has worsened significantly during the past year. Three conclusions should alarm anyone concerned about the financial future of our country:

1. Social Security, Medicare and Medicaid will nearly double as a percent of GDP by 2030.

2. Social Security outlays will exceed earmarked tax revenues by a widening margin beginning in 2016. In this year Treasury will have to redeem the trust fund IOUs with cash that can only be obtained from cutting spending, raising taxes, or borrowing more money;

3. Even without a prescription benefit these programs along with net interest payments, would require roughly three-quarters of total federal revenue in 30 years leaving the Federal government in a position of doing little more than mailing checks to the elderly and their health care providers.

All of this said I know there is tremendous pressure on you from 35 million elderly Medicare beneficiaries, 5 million disabled and their families, who are telling you they need help to lessen the burden of paying for their pharmaceuticals. I know you have been moved by stories of individuals who simply do not know where they are going to get the money to pay for a life saving prescription ordered by their doctor. And I know that few things affect us more directly than health care.

Still, I urge caution. Medicare is social insurance with an asterisk. The asterisk informs us that the program is, for several reasons, not insurance. First of all it is not fully funded. The current unfunded liability for future beneficiaries is $10 trillion before a prescription drug benefit is added. Second, it is not true insurance because the insurer is underwriting a risk that is almost certain to be used continually. This is especially true with most of the prescription drug proposals where the usage will be expected and annual.

I also urge caution because money is money. By that I mean that the distinction between government money and private sector money is an ideological distinction not a real one. While it is true that some health care spending can grow the private sector (look at the impact of government spending on rural counties, for example), the sale of goods and services in the private sector generates the revenue taxed by the government for its services.

This is not an academic argument. Too many citizens answer the question where are we going to get the money for a prescription benefit with: The government will pay for it. Current beneficiaries need to understand that most of the money for this benefit will not come from them. Most of the money will come from a tax on the wages and salaries of Americans who are in the work force. And a growing number of these workers, who are seeing an increasing share of their income going to insure someone else, do not have health insurance themselves. These workers are also the ones who suffer the negative consequences of having too little to spend on education, childcare, transportation and technology.

Current beneficiaries also need to understand that there is a limit to Federal spending. Since the Second World War the Federal government has rarely removed more than 20 percent of the U.S. economy for taxes. Federal spending since the Second World War has never gotten above the 23.5 percent of GDP it reached in 1983 and for the most part has hovered around 20 percent. This 20 percent number has remained relatively constant and was trending downward during the 1990's economic expansion. What has not remained constant is the mix of Federal spending within that 20 percent. While spending on health and other entitlements has risen, spending on defense and non-defense appropriations has taken up a declining share of the budget and the economy. This trend is forecast to continue.

When the baby-boom generation begins to retire in 6 years Medicare spending will increase rapidly as a percentage of our Federal budget. As a consequence, something

has to give. With history as our guide the likely loser will be spending on the programs that will benefit the working families who are being taxed more and more to pay for someone else's health care.

This, the first question that should be asked and answered is not do we need a prescription drug benefit but can we afford it? Those of us who thought we might be able to afford it were given a wake-up call to what beneficiaries will eventually demand when the American Association of Retired Persons submitted a proposal that would cost $750 billion. If prescription drug costs continues their recent 20% annual increases even this estimate may turn out too low.

Members of the Finance Committee, I do not think that doing nothing is an option. Americans can afford a prescription drug benefit but I do not believe we can afford to add it to Medicare as it is currently structured. More challenging I do not believe we can solve this problem by focusing on benefit changes or reductions in reimbursements to providers. Instead I believe we need to focus our attention on fundamental reform of the way Americans become eligible under Federal law for health insurance.

Though intuition is often a good guide when making decisions sometimes it fails us. In this case intuition signals that we should narrow the scope of our Federal health care entitlement programs in order to save money. However, I believe the counter-intuitive choice, namely to expand the entitlement, is the least costly choice.

By expand the entitlement I mean we should change the language of Federal law so that Americans become eligible for health care as a consequence of their having proved they are Americans or legal residents rather than the way they do under current law. Under current law there are seven ways a resident of the United States can become eligible for insurance:

1. Work forty quarters and wait until they are 65;
2. Demonstrate they are disabled;
3. Get blown up in a war;
4. Prove they are poor and promise to remain poor;
5. Join a military service or work for the Federal government;
6. Find a job with an employer who uses the tax code to reduce the cost of purchasing insurance.
7. Have a kidney that requires dialysis.

Under current law the only people who are not eligible are 40 million uninsured Americans who aren't old enough, disabled enough, poor enough or lucky enough to qualify. On the other hand all 40 million are eligible to have taxes collected from them to pay the subsidies for all the rest of us who have met a statutory test.

I urge you to consider that for budgetary, economic and moral reasons we cannot get from where we are now to where we want to go by adding a new and expensive benefit to an existing entitlement program. Nor can we get there by just reforming existing programs. We can only get there by fundamentally altering the way we become eligible for insurance in the first place.

Beginning with a universal entitlement does not mean higher spending or more governmental interference with the choices made by patients or providers. In truth it could mean a lot less of both. It would mean that we would start thinking about ourselves as a single group of 280 million Americans who are all part of the same health system and who all need to face the challenge of matching our appetite for quality with our capacity to pay.

No doubt this proposal seems a little out of place in a hearing on a prescription drug benefit. But those of you who know me—and who invited me to testify anyway—are familiar with my tendency to say things that are out of place. In this case I do not believe a fundamental change in the way we become eligible for health insurance is out of place. I strongly believe it is the only way we can enact a prescription drug benefit we can afford that does not make matters worse for all those working families who will be paying for it.

Finally, while technology and the trend towards longer life expectancies have increased the cost of Medicare and Social Security we should not let the actuaries persuade us that this is bad news. In my case I will need that extra longevity in order to attend my second son, Henry's, college graduation in 2022. In many other cases Americans are entering the last phase of their lives with more optimism and health than ever before in part thanks to Medicare and Social Security. I trust that you have the wisdom and the desire to make certain both will be there for many generations to come.

PREPARED STATEMENT OF PATRICIA NEUMAN, SC.D.

Thank you, Mr. Chairman and Members of the Committee, for the opportunity to testify on the issue of prescription drug discount card programs 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 Bloomberg School of Public Health.

Prescription Drugs and the Medicare Population

Medicare plays a critical role in the lives of over 40 million elderly and disabled Americans, offering a reliable source of health insurance at a time in their lives when they are most likely to need medical care. Medicare pays for much-needed basic medical services, such as physician and hospital care, but does not generally does not pay for outpatient prescription drugs. This gap in Medicare's benefit package is a growing problem given the rising costs of prescription drugs, the increasingly central role they play in medical treatment, and the erosion of drug coverage available to seniors through other sources.

More than a quarter (27%) of all beneficiaries lacked drug coverage for the full year in 1998 and as many as 38% of all Medicare beneficiaries were without prescription drug coverage in the Fall of 1999, the most recent year for which national survey data are available (Exhibit 1). Using the same point-in-time estimates, half of all beneficiaries living in rural areas and 45 percent of seniors ages 85 and older lacked drug coverage in 1999. 1999 Most beneficiaries get help from their drug expenses through supplemental insurance. However, coverage under private-sector sources—including employer-sponsored programs and Medicare+Choice plans—is eroding while premiums for Medigap drug policies are escalating. And, while Medicaid has traditionally been a critical source of drug coverage for Medicare's lowest-income population, a growing number of states are turning to a range of strategies to contain drug spending, given that prescription drugs are the fastest-growing cost item in the Medicaid program (Exhibit 2). These changes could further diminish drug coverage for elderly and disabled beneficiaries.

Seniors rely heavily on prescription drugs—filling four times as many prescriptions as do younger adults ages 19 to 44 (Exhibit 3). The Medicare population tends to have high rates of multiple chronic conditions, such as arthritis, hypertension, and heart disease, which are commonly managed with medications (Exhibit 4). At the same time, a large share of Medicare beneficiaries live on modest incomes, limiting their ability to purchase needed medications or absorb high drug costs in the absence of adequate drug coverage. Four in ten beneficiaries live on an income below twice the federal poverty level, or below about $16,000 for an individual and $22,000 for a couple in 1999 (Exhibit 5).

Evidence suggests that seniors without coverage are less likely to take medications as prescribed by their doctors, sometimes skipping doses and splitting pills because they are unable to pay the full cost of their prescriptions. Those without drug coverage fill fewer prescriptions than do those with insurance, yet pay more out-of-pocket for their medicines (Exhibit 6). Beneficiaries without drug coverage typically pay more out-of-pocket than do seniors with insurance for two reasons: They do not have the benefit of an insurer to cover a portion of their drug costs, and they often lack access to the same discounts that insurers typically negotiate with pharmacists or manufacturers. The predicted increase in prescription drug spending for the Medicare population will put seniors without drug coverage or access to substantial discounts at even greater risk in the future (Exhibit 7).

Against this backdrop, making prescription drugs affordable for seniors has become a top priority for policymakers and the general public. While debate continues on proposals for a universal Medicare drug benefit, the Bush Administration has proposed a range of incremental measures, including a new Medicare-Endorsed Prescription Drug Card Assistance Initiative as an interim strategy to help beneficiaries buy prescription drugs at lower costs. This approach would build upon the range of private and publicly sponsored discount card programs currently in operation.

Overview of Existing Prescription Drug Discount Card Programs

To help understand the operations and benefits of existing private discount card programs, the Kaiser Family Foundation commissioned a study by Health Policy Alternatives to assess their implications for consumers.[1] As reported in that study,

[1] *Prescription Drug Discount Cards: Current Programs and Issues*. Prepared by Health Policy Alternatives for the Kaiser Family Foundation, February 2002.

there is currently a wide array of prescription drug discount card programs in operation.

Private-Sector Discount Card Programs. The majority of these are voluntary programs sponsored by private entities such as pharmacy benefit managers (PBMs) and retail stores (e.g., chain pharmacies). Many discount card sponsors market directly to consumers, but others offer programs through intermediaries, such as employers, insurers, associations, and financial institutions. Many Medigap carriers, for example, offer discount cards in conjunction with their Medigap policies to help enrollees pay for prescription drugs. Employers and insurers may offer discount cards, either as a supplement to existing insurance coverage or because their plan does not cover prescription drugs. Membership-based organizations may sponsor discount card programs as a means of attracting and retaining members. In some cases, the programs offer benefits in addition to prescription drugs, such as discounts on dental and vision services.

In general, consumers may enroll in any number of these programs and receive discounts on their prescription drugs at the point of sale. The vast majority of these programs are marketed nationwide and are available to the general public, regardless of income or age. Typically, there is an enrollment fee, which may be charged on a one-time, monthly, or annual basis.

For the most part, private discount drug card programs are unregulated, as they are not These programs are generally not considered to be insurance. There are exceptions, however; some states, although a few states require discount card companies to register as insurance companies and also require discount card sponsors to comply with rules related to. Some states impose restrictions on marketing practices. For the most part, however, these programs are unregulated.

Discount card programs are able to offer savings off retail prices at the point of sale to their enrollees through a combination of lower dispensing fees paid to pharmacists, the use of internet and mail-order pharmacies, and lower manufacturer prices negotiated through volume discounts or rebates. These programs vary widely in terms of where and how consumers may purchase their drugs in order to obtain discounts (i.e., in retail pharmacies, by mail-order, or over the internet), the magnitude of the savings offered, and the particular drugs to which the discounts apply. Most of the consumer discount is believed to be the result of concessions on the pharmacy mark-up and dispensing fees, rather than the manufacturer rebates. According to the report prepared by Health Policy Alternatives, among the cards that get rebates from manufacturers, there is considerable variation in the degree to which the rebates are passed on to consumers in the form of lower prices.

Other Prescription Drug Discount Card Programs. Along with discount cards sponsored by private entities, there are at least five states that now offer a discount program card to help reduce drug costs for Medicare beneficiaries (California, Florida, Iowa, New Hampshire, and West Virginia).

In addition, there are now four private discount card programs that are sponsored by drug manufacturers themselves. These programs offer assistance to seniors with modest incomes, although they provide discounts on only the drugs they produce. Two of these (Glaxo SmithKline and Novartis) offer a percentage discount on the purchase of their drugs, while the others, Pfizer and Eli Lilly, charge a flat fee per prescription (of $15 and $12, respectively) for their drugs.

Implications of Prescription Drug Discount Card Programs for Beneficiaries Today

While there appears to be a growing number of private-sector and state-sponsored discount card programs, these programs are relatively new and little is known about how well they are serving their target populations. It is not known, for example, how many people are enrolled in one or more discount card programs, primarily because private card sponsors generally consider enrollment data proprietary. The extent to which these programs are providing meaningful discounts to a significant share of the population in need depends on their capacity to achieve a number of objectives. and how often they use these cards to lower their drug costs.

Reducing Seniors' Drug Costs. There is some evidence that existing drug discount card programs lower costs for seniors. A recent report published by the U.S. General Accounting Office suggests that discount cards generate prices that are lower than typical retail prices—although the relative discounts vary by drug by discount card program, by drug, and by retail outlet (GAO, 2001). While such findings are helpful in terms of understanding the potential magnitude of these programs' impact on price, they do not necessarily speak to the savings to be achieved at the individual consumer level. In addition to price, the degree of assistance provided will depend on the characteristics of consumers themselves, including the number and type of medications they take and the length of time they are on a given drug regimen. Fur-

ther research is needed to assess the magnitude of the savings achieved under existing discount card programs for seniors.

While discount card programs appear to lower drug costs for consumers, they are not a substitute for drug coverage. When a seniors goes to a pharmacy with a discount card, they tend to pay less than full retail price, but still pay substantially more than they would if they had drug coverage and were only required to pay a share of total costs. Exhibit 810 presents illustrative prices for medications commonly purchased by the elderly and compares the out-of-pocket expenses that a typical senior might face under three scenarios: (1) the senior pays the full retail price, with no drug coverage or discount card; (2) the senior uses a discount card; and (3) the senior has health insurance under the Blue Cross/Blue Shield PPO offered under the Federal Employees Health Benefits Program (FEHBP). Based on available price data from current discount programs and retail outlets, discount card users would pay less out-of-pocket per prescription than would seniors paying full retail price, but substantially more than those with meaningful insurance coverage, such as that provided under this particular FEHBP plan (assuming these drugs are included in the plan's formulary).

Finally, while discount drug card programs lower costs, they are unlikely to make medications significantly more affordable for beneficiaries living on a fixed income. Take, for example, an elderly woman with an annual income of $15,615, or about $1,300 per month (the mean income for women ages 65 and older in 1999), who is prescribed the four medications listed in Exhibit 8. She The mean income in 1999 for elderly women is $15,615, or $1,301 per month. Thus, an elderly woman requiring each of the medications listed in Exhibit 10 would save money using her discount drug card, but still have to spend about 25 percent of her monthly income filling her prescriptions—with or without the discount card. By contrast, if she had drug coverage under the FEHBP PPO, her prescriptions would account for roughly 8 percent of her income.

Facilitating Cost Comparisons for Consumers. Consumers face a number of challenges comparing existing discount card programs in deciding which programs would best meet their needs. There is currently wide variation in the nature of price information made available by discount card programs and there is no central place to access and compare information across programs. As a result, seniors must contact each program individually to obtain prices. Many discount card programs—6 of the 14 private discount card programs surveyed by Health Policy Alternatives—do not list drug prices or discounts on their own websites (Table 1).

Among the programs that do provide price or discount information on their websites, direct price comparisons are not always possible because they do not use a common benchmark or reference price. While some plans provide price information for specific medications by dose level, others present it in a way that is far more would be difficult for consumers to understand or compare. For instance, some programs present discounts for a given drug as the retail price (which is not specified) minus a percentage. Others report discounts as the dollar amount of the discount itself, without referring to the base price at all. This variation has implications not only for consumers, but also for the feasibility of deriving accurate estimates of the savings that consumers actually receive.

Additional sources of potential confusion include variations in enrollment fees, the range of additional benefits offered under discount card programs such as dental or vision discounts, frequent fluctuations in drug prices, and shipping fees for mail-order purchases, where available. Taken together, variation along all of these dimensions may be especially problematic for the Medicare population. Only 16 percent of the elderly report being regular users of the internet, although this share is increasing rapidly (Vastag, 2001). A recent study found that more than half of all Medicare beneficiaries have difficulty comparing information about health plans (Hibbard, 2000) and almost a quarter have cognitive impairments (Kaiser, 2002). This suggests that a substantial share of the Medicare population may not be able to choose among a range of discount card programs in deciding which one best meets their needs.

Monitoring and Improving Quality. Discount card programs also vary in their quality assurance and patient safety programs. Some programs, for example, provide access to a pharmacist through a toll-free hotline, along with information on appropriate dosages and possible side effects. A limitation of these programs is that they take into account only those drugs that are purchased with the card, without regard to other medications that the consumer may be taking or other underlying health conditions.

These quality features can be important to seniors and younger Medicare beneficiaries with disabilities, particularly those who are among the highest users of medications. However, there is some concern that discount card programs may have

an incentive to steer consumers to drugs for which the programs themselves will receive the greatest rebate, rather than to the specific drugs considered clinically optimal by the patients' physicians. The pressure to substitute discounted drugs for those initially prescribed may pose concerns about quality of care.

In sum, private discount card programs are currently an option for lowering the cost of drugs for seniors who tend to pay full retail. Discount programs today are voluntary, generally unregulated, and vary widely in many ways. Seniors are free to sign up for more than one program, and may use multiple cards to get the best possible savings. The evidence to date suggests that discount cards lower costs, but little is known about the magnitude of savings offered by these programs and the number and characteristics of people they serve.

Medicare-Endorsed Prescription Drug Card Assistance Initiative

Last week, the Administration issued a proposed regulation to establish a Medicare-Endorsed Prescription Drug Card Assistance Initiative as a first step and building block for a possible Medicare drug benefit. The Administration's proposal differs from the status quo in several ways. Most significantly, it would create and authorize the use of a Medicare-Endorsed Prescription Drug Assistance Emblem that could be used by discount card sponsors that meet specified qualifications. It would also highlight Medicare-endorsed card programs in Medicare publications, brochures, enrollment publications, and on the program's website, as part of a broader package of beneficiary education activities. Medicare-endorsed card sponsors would be required to assure that beneficiaries enroll in only one qualified program at a time in order to give sponsors greater leverage in negotiating rebates or discounts from manufacturers. A new consortium, funded by contributions from qualified sponsors, would be established to monitor the activities of Medicare-endorsed programs.

A new Medicare discount card program has the potential to lower drug costs for seniors, provide new information to help consumers compare prices across Medicare-endorsed programs, and enhance patient care by encouraging programs to establish improved quality assurance programs. At the same time, a new Medicare-endorsed discount card program raises several issues for consideration.

Would a Medicare-endorsed discount card program provide greater discounts than those currently available under existing discount card programs? Given the challenges of both comparing discounts across programs today and estimating savings either nationally or at the individual level, this question is difficult to answer. Existing discount card programs lower costs for beneficiaries who typically pay the full retail price when they fill their prescriptions. A new Medicare-endorsed card could lower costs somewhat further Existing discount card programs generally help to lower costs for consumers who would otherwise pay full retail. Under a Medicare program,as discount card sponsors may be able to attract more beneficiaries as a result of the Medicare endorsement and thus negotiate higher discounts and rebates. If, however, such discounts do not apply to all drugs within each therapeutic class, then the number of people who would be helped under such a program would be limited. Furthermore, unless a minimum discount is required, the extent to which these efforts would result in lower prices than those currently available to seniors is uncertain.

Would a Medicare-endorsed discount card program help beneficiaries compare drug prices across programs? One of the challenges facing seniors today is the absence of a central information source to compare drug prices across programs. A Medicare-endorsed discount card program could provide consumers with direct access to information about participating programs, allowing consumers to compare prices for the medications they take. This would be a significant improvement over the status quo—particularly if prices were presented in a standard way across programs and in terms that consumers could readily understand and compare.

Would Medicare-endorsed discount card sponsors be required to meet minimum standards to assure quality and guard against marketing abuses? In the current environment, with few exceptions in a small number of states, discount card programs are unregulated. If card sponsors are required to meet certain minimum standards, then consumers could be offered greater protections than they have today.

In the past, Congress has explicitly prohibited the inappropriate use of the Medicare name, limited the circumstances under which private entities may market Medicare-label products, and established federal oversight and enforcement procedures to assure compliance with federal standards. For example, in 1980 and again in 1990, Congress stepped in to protect consumers from well-documented problems in the Medicare supplemental insurance (Medigap) market by imposing new stand-

ards for benefits, sales practices, and loss ratios; and by establishing penalties for non-compliance.

Appropriate and enforceable standards for discount card sponsors bearing the Medicare name are important given the vulnerability of the Medicare population and many seniors' urgent need for help with their drug costs. Attention to privacy concerns may be especially critical given the potential for sponsors and drug manufacturers to share beneficiary information for marketing purposes.

Finally, extending the Medicare name to private discount card programs could potentially raise expectations among seniors that a Medicare-endorsed card would provide a minimum, guaranteed benefit—or, in this case, a discount of some minimum amount. In return for allowing private firms to benefit from Medicare's good name and reputation, it may be worth considering standards to require card sponsors to provide a minimum, guaranteed discount—as a condition for receiving the Medicare seal of approval.

Would a Medicare-endorsed discount card program make prescription drugs more affordable for seniors? As the Administration notes, the proposed Medicare discount card program would not deliver the same level of savings to seniors as a Medicare benefit. Recent public-opinion surveys indicate that making prescription drugs affordable for seniors remains a high priority for the public (Exhibit 9). And, while a recent Kaiser Family Foundation poll finds the public paying close attention to developments related to discount cards, focus groups conducted for the Foundation indicate a high level of public support for a meaningful Medicare drug benefit, comparable to what many insured workers get today (McInturff and Garin, 2001).

Given the high level of public interest in Medicare and prescription drugs, educating the public about a new Medicare discount card program—how it works and how it differs from a full Medicare drug benefit—could be critically important for minimizing confusion among seniors.

Summary

Today, a wide variety of discount card programs are available to seniors to help lower the costs of prescription drugs. Many of these programs are relatively new. The programs vary widely in terms of how they operate, the savings they offer, and ultimately, their impact on consumers. A Medicare-endorsed discount card program could help lower drug costs and could help provide an infrastructure that would lay the foundation for a Medicare drug benefit. However, even a successful Medicare discount card program will not be a substitute for meaningful drug coverage for the Medicare population.

Table 1: Illustrative Retail Prices for Discount Card Programs for Selected Prescription Drugs (90 units unless otherwise indicated)

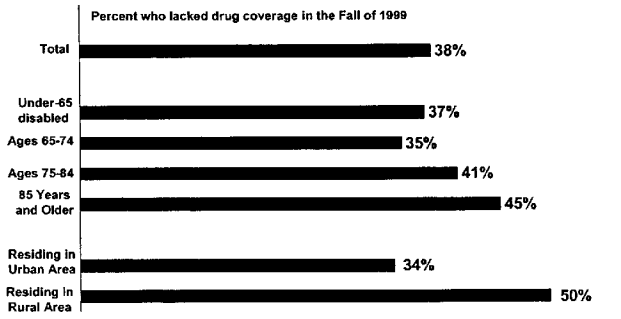
Program		CVS	YOURx PLAN	SaveWell	Qdrug	ProCare ValuCard	Pharmacy Card[ii]	Peoples[iii]	Member Choice (AARP)	Magna Card	Member Health[iv]	EHO	Rx Universe	Advance PCS	Citizens Health
Annual membership/ Enrollment fee		$69.95 - 2 person household	$25-single $40-family	$84-family member	$49.95-single $99-family	$71.40 (plus one time sign up fee)	$48-single $60-family $0-seniors (not advertised)	$71.40-family	$15-single $30-single + spouse	$25 ($10 from Member Health)	$10-family	$39.95	$19.99-single $39.99-family ($4 web discount)	No fee to enroll	$12-single $28-family
Drug	**Therapeutic class**														
Celebrex 200mg (Brand)	Anti-inflammatory/ Analgesia	Online quotes not available	$201.58	$67.69 (30 units)	Online quotes not available	Online quotes not available	Retail price minus 19%	Avg disc of $10.42	$192.54	Online quotes not available	Not listed	Online quotes not available	Online quotes not available	Online quotes not available	Online quotes not available
Furosemide 40mg (Generic)	Loop diuretic		$8.89	$3.91 (30 units)			Retail price minus 57%	Avg disc of $3.24	$7.00		$7.46				
K-Dur 20mg (Brand)	Potassium replacement		$42.10[i]	$16.67 (30 units)			Retail price minus 26%	Avg disc of $4.86	$43.01		$50.00 - 100 units				
Lanoxin 0.25mg (Generic)	Cardiac glycoside		$12.65	$7.14 (30 units)			Not listed	Avg disc of $1.74	$9.95		$8.15 - 30 units				
Norvasc 10mg (Brand)	Calcium channel blocker		$157.01[i]	$53.75 (30 units)			Retail price minus 21%	Avg disc of $7.26	$166.34		$60.25 - 30 units				
Premarin .0625mg (Brand)	Estrogen replacement		$62.07	$21.71 (30 units)			Retail price minus 26%	Avg disc of $3.54	$53.31		$21.08 - 30 units				
Prilosec 20mg (Brand)	Gastrointestinal agent		$308.58[i]	$114.25 (30 units)			Retail price minus 4%	Avg disc of $12.58	$329.01		$115.75 - 30 units				
Synthroid 1.0mg (Brand)	Synthetic thyroid		$33.43	$12.28 (30 units)			Retail price minus 33%	Avg disc of $2.98	$30.12		Not listed				
Zocor 20mg (Brand)	Lipid lowering agent		$331.98	$110.66 (30 units)			Retail price minus 16%	Avg disc of $11.58	$318.49		$114.81 - 30 units				
Fosamax 10mg (Brand)	Osteoporosis treatment		$166.88	$62.36 (30 units)			Retail price minus 24%	Avg disc of $9.11	$176.93		$63.87 - 30 units				

SOURCE: Reprinted from *Prescription Drug Discount Cards: Current Programs and Issues*, prepared for the Kaiser Family Foundation by Health Policy Alternatives, Inc., February 2002.
Note: prices change frequently; quoted mid-Nov.

[i] Includes cash back savings -- 10% extra savings sent with a quarterly statement.
[ii] Discounts expressed as a percentage savings off of retail price. No information is provided on strength or quantity of the medication.
[iii] Discounts are expressed as average savings off of retail price. No information is provided on quantity of the medication and prices vary by pharmacy.
[iv] Prices are expressed as the average member price and will vary by pharmacy.

Exhibit 1

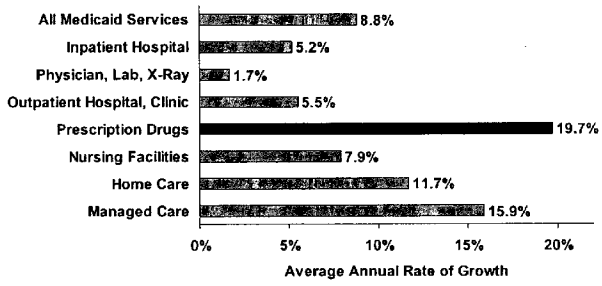
Percent of Medicare Beneficiaries Lacking Drug Coverage, Fall 1999



SOURCE: Laschober, et al., *Health Affairs*, February 27, 2002; Point-in-time estimates based on analysis of 1999 MCBS Access to Care Files.

Exhibit 2

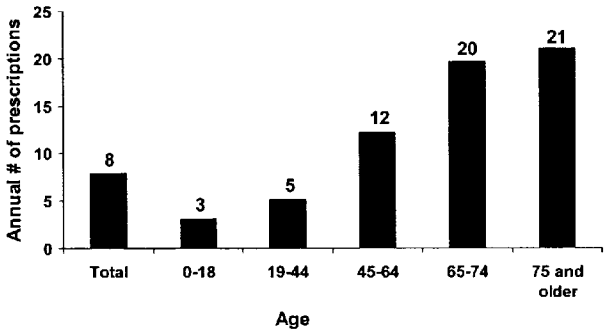
Average Annual Rate of Growth in Selected Medicaid Expenditures, 1998-2000



Note: All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed (except for 'managed care,' which includes a wide range of medical services).
Source: CMS, CMSO, Financial Management Reports (HCFA-64 data).

Exhibit 3

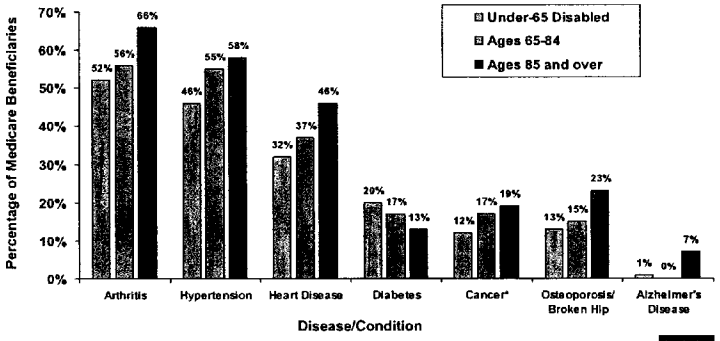
Prescription Drug Utilization, By Age, 1996



SOURCE: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996.

Exhibit 4

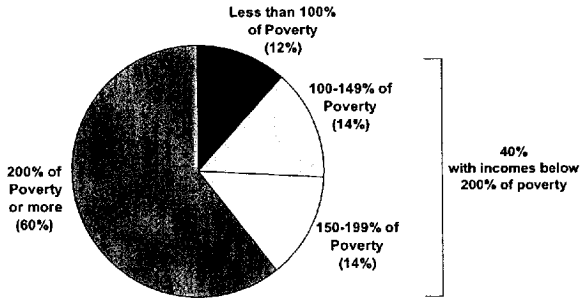
Chronic Conditions Among Non-Institutionalized Medicare Beneficiaries, 1999



*Excludes skin cancer.
Note: Excludes institutionalized beneficiaries.
SOURCE: Barents Group of KPMG Consulting's analysis of the 1999 Medicare Current Beneficiary Survey.

Exhibit 5

The Non-Institutionalized Medicare Population, by Poverty Level, 1999

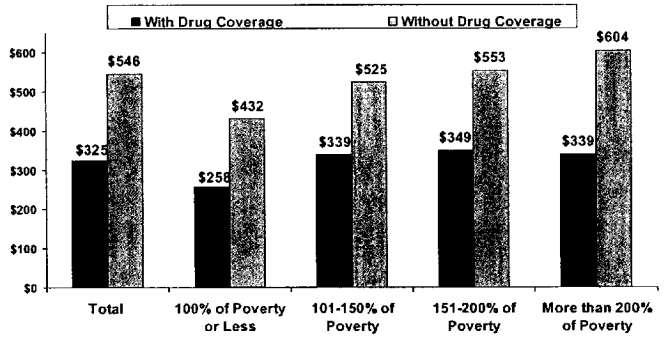


Total = 36 Million Medicare Beneficiaries

Note: Reflects income from all household family members. 1999 federal poverty level: $8,240 for individuals; $11,060 for couples.
Source: Urban Institute estimates based on 2000 Current Population Survey.

Exhibit 6

Out-of-Pocket Drug Spending Among Non-Institutionalized Beneficiaries, by Drug Coverage and Poverty Status, 1998

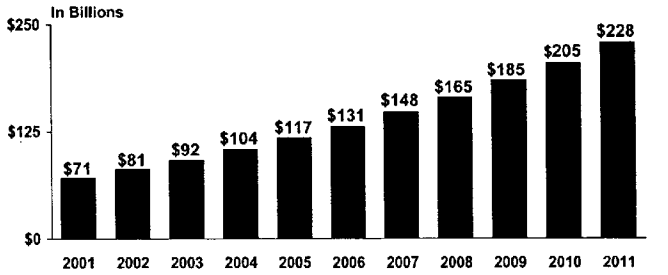


Source: CMS, 2002.

Exhibit 7

Projected Prescription Drug Spending for the Medicare Population, 2001-2011

(Total = $1.5 trillion)



SOURCE: CBO, January 2001 baseline.

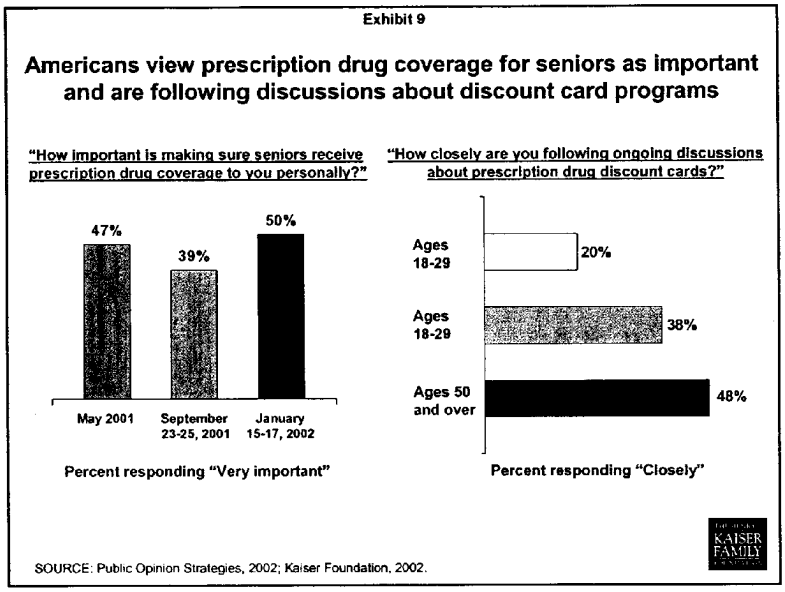
Exhibit 8

Illustrative Comparison of Retail Prescription Drug Prices

Drug	Washington, DC Average Retail Price (a)	Discount Card Retail Price (b)	FEHB BC/BS PPO Co-payment (c)
Prilosec, 20mg (Gastrointestinal agent)	$121.64	$115.00	$25.00
Zocor, 20mg (Lipid lowering agent)	$122.25	$112.79	$25.00
Premarin, .625mg (Estrogen replacement)	$22.84	$21.40	$25.00*
Celebrex, 200mg (Anti-inflammatory/ Analgesia)	$80.34	$67.69	$25.00
Monthly Total	$349.07	$316.88	$100.00

* Consumer would pay retail price if lower than the co-payment.

- Washington, DC average price reflects the average of prices obtained from five area drug stores, as reported by the GAO. (GAO-02-230R), December 5, 2001.
- Discount card prices are the average of two discount card programs that display prices for 30-day units, as displayed in Prescription Drug Discount Cards: Current Programs and Issues, prepared for the Kaiser Foundation, February 2002.
- FEHBP BC/BS figures are for on-formulary brand-name drugs, based on opm.gov/insure/02/htm/standard/guides/70-1.pdf



RESPONSES TO QUESTIONS FROM SENATOR LINCOLN

Question 1: Recently, the GAO released a report indicating that drug discount cards currently on the market generally offer minimal and scattered discounts. You've heard Tom Scully claim that a Medicare-endorsed drug discount card would save seniors at least 15 percent. Do you agree with this figure? In your opinion, is the Medicare endorsement enough to yield greater discounts than cards currently offer?

Answer: It is difficult to determine the size of the discounts that could be achieved under a Medicare-endorsed discount card program. While many existing private-sector discount card programs do offer consumers some savings, these discounts tend to vary both across programs and by drug. To date, there have been no studies that document the extent of savings provided to consumers from discount card programs either on an aggregate or individual basis.

A Medicare-endorsed program could have the advantage of using the Medicare name to attract more beneficiaries and negotiate higher discounts and rebates than those currently offered under existing programs. If, however, such discounts do not apply to all drugs within each therapeutic class, then the number of people who would be helped under such a program would be limited. Furthermore, unless a minimum discount is required, the extent to which these efforts would result in lower prices than those currently available to seniors is uncertain.

Question 2: In your study of the discount cards currently on the market, where do the savings for the discounts come from? (Pharmacists or drug manufacturers?)

Answer: The savings achieved under private-sector discount card programs are the result of both concessions on the fees paid to pharmacists and manufacturer rebates. However, based on interviews conducted for a recently released Kaiser Foundation report on these programs prepared by Health Policy Alternatives, it appears that the majority of the discounts that are actually passed along to consumers reflect the reduced pharmacy mark-up and dispensing fees achieved through negotiations with participating pharmacies. The manufacturer rebates, on the other hand, appear to be retained in large part by PBMs and other discount card program sponsors.

Question 3: Seniors take many prescription drugs and a discount card may not provide a discount on every drug that a senior may take. One card may provide a discount on a popular arthritis medication and another card may provide a discount on a popular heart medication. If beneficiaries are restricted to one drug card, as specified in the Administration's proposal, could a senior end up paying more for their prescription drug costs?

Answer: The Medicare-endorsed discount card programs that have been proposed by the Bush Administration differ from existing discount programs in that consumers would not be allowed to enroll in more than one endorsed program at a time. As programs will not be required to provide discounts on all drugs, the amount that elderly consumers taking multiple medications end up paying will depend on the discount card program they select and the level of discounts offered on the specific drugs they take. In addition, consumers could see their drug costs rise after they enroll in a discount card program if the discounted price of their medications rises or if their health-care needs change.

PREPARED STATEMENT OF WILLIAM D. NOVELLI

Mr. Chairman and members of the Committee, I am Bill Novelli, Executive Director and CEO of AARP. On behalf of the organization and our 35 million members, I want to thank you for convening this hearing and for continuing your efforts to consider examine proposals for reforming Medicare and the best approaches for adding a much needed prescription drug benefit to the Medicare program..

As AARP looks toward building retirement security for today's older Americans and the baby boom population, we believe no person is economically secure without adequate medical insurance. The structure of retirement security is no longer simply the "three-legged stool" of Social Security, private pensions, and personal savings, but rather four pillars consisting of: Social Security, pensions and savings, earnings, and, importantly, stable, affordable and adequate health insurance.

Consequently, now more than ever, Americans of all ages are looking to Medicare's guarantee of affordable health care coverage as part of the foundation of their retirement planning. But there is a serious gap in Medicare's protection—the absence of reliable prescription drug coverage. AARP believes that in order for Medicare to remain strong and viable for today's beneficiaries, and for those who will depend on it in the future, we must confront the key challenges facing the program. Key among them is providing outpatient prescription drug coverage.

While modern medicine increasingly relies on drug therapies, the benefits of these prescription drugs elude more Medicare beneficiaries every day. Drug costs continue to rise unabated. Employer-based retiree health coverage is eroding. Managed care plans in Medicare have scaled back their drug benefits. The cost of private coverage is increasingly unaffordable. State programs provide only a limited safety net. Therefore, the need for a Medicare drug benefit will only continue to grow.

Given the prominence of drug therapies in the practice of medicine, if Medicare were being designed today—rather than in 1965—not including a prescription drug benefit would be as absurd as not covering doctor visits or hospital stays. That is one of the reasons why ensuring that Adding prescription drug coverage is included in to Medicare's defined benefit package is AARP's number one legislative priority this year. Our members and their families need and expect a meaningful benefit that is affordable and available to all beneficiaries. They expect us to be their champion on this issue and we will be.

We are pleased to be here today to discuss the President's budget proposal for prescription drugs and Medicare reform and to share with you some initial findings of what our members need in terms of Medicare prescription drug coverage.

The President's Budget Request & Proposal to Modernize Medicare

The President's FY 2003 budget request includes $190 billion over the next ten years for to "modernize" Medicare with prescription drugs coverage and other changes. AARP is pleased that the President continues to make Medicare prescription drug coverage a priority for his Administration and has indicated his willingness to work with the Congress on this issue.

The Administration's budget does not provide details on how it would address the need for an affordable prescription drug benefit, but the dollar amount proposed in the President's budget is insufficient for an affordable and meaningful drug benefit for all Medicare beneficiaries. A brief review of the various components of the President's Medicare proposal highlights AARP's concerns.

Low-Income Proposal—Out of the $190 billion in the President's budget, $77 billion in Medicare dollars are earmarked for low-income drug coverage. The budget proposes an enhanced federal match to enable states to cover drug costs for Medicare beneficiaries between 100 and 150 percent of poverty.

While we must provide additional financial assistance for low-income individuals, low-income assistance is *not* a substitute for a prescription drug benefit in Medicare. Also, proposals to provide additional financial assistance for low-income individuals should be clear as to how the proposed targeted low-income assistance would be

used (e.g., in Medicaid expansions or state pharmacy assistance programs), how this effort would improve the current patchwork of drug assistance available, and how many people would actually be helped. For instance, 17 states and the District of Columbia have assistance programs up to 100 percent of poverty. The Administration's budget would "allow states to expand drug coverage to Medicare beneficiaries up to 100 percent of poverty" but does not provide any additional assistance for states to do so. It leaves open the question of whether states that could not raise their Medicaid thresholds would be eligible for the new enhanced federal match between 100 to 150 percent of poverty.

The Administration's proposal does not include a maintenance-of-effort requirement to prevent "dollar trading" by the states that already have higher thresholds. Those states that already cover beneficiaries up to 150 percent of poverty might substitute federal dollars for their current commitment and not expand their state efforts. Without safeguards, the end result for $77 billion in federal funding could be little or no extension of prescription drug protections for needy seniors.

Discount Card—The President's budget includes the Administration's proposal to implement a Medicare drug discount card that would give beneficiaries immediate access to drug discounts and other pharmacy services. Medicare would endorse cards that meet criteria for customer service and other key functions. Card sponsors would negotiate discounts with manufacturers and retailers, thus lowering drug prices for beneficiaries. The proposal has now been released in the FEDERAL REGISTER as a proposed rule.

AARP is encouraged that—unlike current industry card proposals—the President's proposed discount card is designed to establish the drug card program as a building block for a full Medicare drug benefit. We emphasize, however, that neither the Administration's discount card or the current industry cards are a substitute for a real drug benefit.

We also believe that while the actual discounts would be relatively modest, the President's discount card program would provide at least some help to beneficiaries in buying the drugs they need. It could provide important safeguards to improve the appropriate use of prescription drugs, and this could help avoid unnecessary health care costs due to drug interactions, mis-medications, or poor compliance. It also, importantly, would help the federal government learn valuable lessons about the pharmacy benefit managers (PBMs) that run discount card programs and are included as the delivery system in virtually every drug benefit proposal before Congress. As a result, it will help the Medicare program become more familiar with how PBMs and drug benefit programs work.

AARP plans to work with the Administration as it continues to refine the drug card proposal. There are several issues that we will try to clarify and some consumer protections we will try to add, including: defining what constitutes a "substantial" discount, obtaining firm details on how manufacturer discounts will be disclosed and passed on to consumers, assuring that consumers can compare drug card discount rates to actual retail prices, and making sure drug cards help consumers get generic drugs whenever they are medically appropriate and the least costly option.

Medicare Modernizations—The President's budget includes approximately $116 billion for Medicare program "modernizations." Included in the total is funding for enhanced Medicare+Choice payments, some preventive services, and prescription drug coverage. The President's budget also includes a new solvency trigger for Medicare spending. We are concerned that the limited amount of funding in the Administration budget for both drug coverage and other program changes is insufficient to add a meaningful drug benefit and strengthen the program for current and future beneficiaries.

AARP supports efforts to modernize the Medicare program. Clearly, the creation of a prescription drug benefit that is available in all Medicare options is the most significant improvement, but other changes are also important and would serve beneficiaries and the program well. For instance, many private health insurance plans offer a cap on out-of-pocket expenses, yet there is no such limit in the Medicare program. Creating an out-of-pocket cap for services currently covered by Medicare Parts A and B would not only bring Medicare more in line with what individuals under the age of 65 currently have, but would also make the program more affordable for beneficiaries.

AARP also remains open to the possibility of combining the Part A and B deductible, provided it is structured to be affordable and does not produce beneficiary "sticker shock." Since most beneficiaries meet the annual $100 Part B deductible but significantly less meet the Part A hospital deductible, a combined and increased deductible will affect the majority of beneficiaries. We are opposed, however, to merging the Part A and B Trust Funds. The new solvency measure included in the

President's budget appears to suggest that Medicare should be financed *wholly* from its Trust Funds. That is, its financing should come predominantly, if not exclusively, from payroll taxes and beneficiary contributions, with little or no contribution from general revenues. This would represent a radical shift in funding for the Medicare program. The impact of such a shift would be to significantly increase beneficiaries' costs for Medicare, reduce provider payments, or a combination of both.

In sum, while the President is to be commended for making Medicare prescription drug coverage a priority, the budget number is insufficient. AARP believes that it would be a mistake to let a low number drive the design of a prescription drug benefit and Medicare reforms, rather than letting the right policy guide budget decisions.

What AARP Members Need

High need, high drug prices, and inadequate insurance coverage pose serious problems for today's Medicare beneficiaries. A chronic health problem necessitating new and expensive prescription drugs can quickly deplete a retiree's financial resources. Even a beneficiary who has planned well for his or her retirement may not be prepared for drug bills that exceed several hundred dollars a month. Further, it is important to note that support for making a prescription drug benefit part of Medicare is overwhelmingly high for all of our members. Americans of all ages recognize the value of prescription drug coverage. In recent polling conducted for AARP, eight in ten Americans age 45 and over favor making prescription drug coverage part of Medicare.

The majority of Medicare beneficiaries—not just those with low incomes—need drug coverage. Because of Medicare's current lack of prescription drug coverage, many beneficiaries must pay for all or some of their prescription drugs out-of-pocket. Although 65 percent of Medicare beneficiaries have some type of coverage for prescription drugs, this figure can be very misleading.

The principal sources of coverage that offer a prescription drug benefit—employer-based retiree coverage, private supplemental coverage, or Medicare HMOs—are often inadequate, limited, expensive, and unstable. Moreover, many Medicare beneficiaries do not have continuous prescription drug coverage. A Commonwealth study released last month reported that nearly 42 percent of beneficiaries lacked drug coverage at some point in 1998. More recently, a new study published by *Health Affairs* reports that nearly 40 percent of Medicare beneficiaries had no drug coverage in the fall of 1999. It is also important to understand that those Medicare beneficiaries without coverage pay top dollar for their prescriptions because they do not benefit from discounts negotiated by third party payers. Most of those currently covered by insurance, including most workers, benefit from such discounted prices.

Let me give you some illustrative examples:

- A retired couple that earns only about $18,000 a year—or about 150 percent of poverty—still is above the threshold for Medicaid in most states and most state and private pharmacy assistance programs. Medigap policies that include prescription drug coverage are unaffordable based on their income, there are no Medicare+Choice plans available in their area, and they do not have access to retiree health benefits through a former employer.
- A retired couple that has significantly saved for retirement and earns $30,000 a year. They have prescription drug coverage through a Medicare HMO. This year they learn, however, that their HMO plans to terminate its contract with Medicare, effective December 31. There are no other Medicare HMOs in their area, and while they can afford supplemental insurance and are guaranteed access to certain Medigap plans (A,B,C, and F), none of these plans include drug coverage.
- A 75-year old widow is enrolled in a Medicare HMO that offers drug coverage. She currently has prescriptions for a cholesterol-lowering medication at $97.51 a month and an allergy medication at $46.94 a month. While initially her drug coverage was quite generous, this year her drug benefit is capped at $300 a year. This means she basically has no drug coverage for three-quarters of the year.

Dependable Drug Coverage—Our members seek **dependable** drug coverage. Current prescription drug coverage options are not reliable. For example, beneficiaries who obtain prescription drug coverage from their former employer are finding that coverage to be unstable. Retiree health benefits that include prescription drug coverage are becoming more scarce. While an estimated 40 percent of employers with 500 or more employees offered retiree medical coverage in 1993, only 23 percent did so in 2001. Of those employers who offered retiree medical benefits, 21 percent do not offer drug coverage to Medicare eligible retirees.

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

- Increasing premiums. Over the past few years, more and more Medicare+Choice plans have been charging premiums for their coverage, and those premiums are escalating. For example, between 2001 and 2002, the percent of Medicare HMO enrollees with zero premiums declined from 47 to 39 percent. This year, nearly one-third of Medicare HMO enrollees (32 percent) will have basic premiums over $50 compared to 14 percent in 2001.
- Higher cost-sharing—Unlike the 1990s, all Medicare HMOs that offer prescription drugs are charging copays for prescription drugs and the average beneficiary copay has increased significantly.
- Decreasing benefit—More plans are lowering the annual cap on the typical Medicare+Choice drug benefit. While in 1999 10.6 percent of Medicare HMOs had an annual cap of $500 or less on their drug benefit, 20.6 percent of plans had a $500 cap in 2000.
- Loss of benefit—Over the last few years several Medicare+Choice plans have dropped their prescription drug benefit entirely. While 88 percent of Medicare HMOs offered some drug coverage in 1999, that number declined to 63 percent in 2001. Although Medicare+Choice has provided beneficiaries with an opportunity for drug coverage, the volatility of the Medicare+Choice market has made that coverage unpredictable and unstable from year to year.

Affordable Drug Coverage—Older Americans also need **affordable** drug coverage. In establishing a *voluntary* drug benefit, the benefit needs to be affordable to assure enough participation to avoid the dangers of risk selection. The government contribution will need to be sufficient to yield a beneficiary premium that is affordable and a benefit design that is attractive to the majority of beneficiaries. If the benefit is not set at an affordable level, only those beneficiaries who have high risk will want to purchase it. This will mean that the only ones in the risk pool will be those with high drug costs and the benefit costs will escalate rapidly into what is often referred to as an "insurance death spiral." This is not simply a matter of what beneficiaries would like to pay, it is an issue of how to assure fiscal viability of the risk pool. Medicare Part B is a model in this regard.

The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation. Actuarial work done for AARP last year by the William M. Mercer Company, and which we shared with the Committee, identified that the key to success for a Medicare prescription drug benefit is to:

- develop a benefit design that will encourage participation by a broad range of beneficiaries in order to spread risk;
- ensure clear and concise communications to improve participation
- balance the breadth of coverage and beneficiary premium;
- implement cost-containment techniques; and
- limit the enrollment period.

We have asked our members and the general public what kind of benefit package would generate this kind of high level of participation in the benefit, and we have learned the following thus far:

- Beneficiaries will generally perform what we call the "kitchen table test" in determining whether they would purchase a new voluntary drug benefit. That is, they will likely calculate their current prescription drug costs, their current Medicare premium ($54 a month in 2002 and rising to $114 in 2010), any drug coverage they might currently have, and their current financial situation, in determining whether a proposed benefit is a real value for them.
- Medicare beneficiaries are willing to pay their fair share for a solid prescription drug benefit, but the premium and coinsurance must be reasonable. We know, for instance, that beneficiaries would not be likely to enroll in a prescription drug plan with a premium of $50 a month.
- While the amount of the beneficiary premium drives the equation, our members also look at the program design features in combination with one another. This means it is difficult to simply assess a single component of a package. For instance, some beneficiaries might look more favorably on a higher level of coinsurance if the premium was lower, or vice versa. In a recent poll conducted for AARP of 885 individuals age 45 and over, only one-third of those 65 and over would be likely to participate in a prescription drug plan that included: a $35

monthly premium, 50% coinsurance, a $200 annual deductible, and a $4,000 stop loss.

- Most Medicare beneficiaries are concerned about the unpredictability of health care costs and want to know what they will be expected to pay out-of-pocket. This makes real catastrophic stop-loss protection that limits out-of-pocket costs an important component of any package. We know from past experience that a $6,000 catastrophic stop-loss is viewed by beneficiaries as too high, and even a $4,000 cap is not viewed as providing much benefit protection.

We will continue to seek the views of AARP members and future members on specific design packages and we would be happy to work with the Committee as proposals are developed.

A Medicare Drug Benefit Requires Adequate Funding

AARP members have told us—through public opinion polling, letters, e-mails and prescription drug events across the country—that they want Congress to implement a Medicare prescription drug benefit. AARP knows that to craft the kind of prescription drug coverage that beneficiaries will find affordable and reliable—and will thus *voluntarily* choose to sign up for—will require a sizable commitment of federal dollars.

We recognize that budget constraints are greater than last year. But while the budget situation changes from year to year, the situation facing millions of older and disabled persons who cannot afford the drugs they need continues to worsen, and constitutes a health care and financial emergency that cannot continue to be ignored.

We fully agree with the sentiment voiced by members of this committee that solid public policy should drive the funding of a prescription drug benefit, not the reverse. That is why we have asked Congress to renew its commitment from last year, adjusted for inflation and another year of coverage, to earmark $350 billion for prescription drugs and reforms that strengthen the program. However, we believe that even this level of funding is inadequate to pay for what our members would consider an adequate and affordable benefit. Therefore, in addition to the $350 billion set-aside for prescription drugs and program reform, we have recommended that Congress create a reserve fund of about $400 billion, or an amount roughly equal to the amount of the 10-year surplus in the Medicare Hospital Insurance (HI) Trust Fund. A majority of the respondents to our recent poll favored borrowing from the Medicare surplus to pay for a prescription drug benefit. Our poll indicates that the combination of the $350 billion commitment based on last year, plus the roughly $400 billion reserve fund, will give the Congress the flexibility it needs to craft a prescription drug benefit that beneficiaries will perceive as having real value.

We do not, at this point, have an estimate of what an adequate drug benefit will cost. We know the plans costing $300 billion offered last year did not find public acceptance. We believe Congress and this Committee should focus on the design of a sustainable benefit that makes sense to beneficiaries and remain flexible as to the projected cost. Through the budget set-aside and reserve fund, the Congressional authorizing committees will be able to develop a drug benefit that beneficiaries need and want. We pledge our assistance in this effort.

Further, since the bulk of funding for a Medicare prescription drug benefit will occur in the last years of the budget window, we view the reserve fund as giving Medicare "first claim" on the unified budget surplus attributable to the surplus in the Medicare Trust Fund forecasted by the Congressional Budget Office.

AARP members fully recognize that there are added priorities and greater budget constraints since last year. However, disease and pain have not disappeared with the surplus and putting off creation of a drug benefit is not going to get any easier. Therefore, we are calling on Congress to act now. This is a priority for our members and the cost of inaction will be great.

In addition to our prescription drug recommendation, we also have said that it would be irresponsible to use Medicare or Social Security surplus dollars to increase provider payments without first ensuring that older Americans get the prescription drug coverage they need. Our members would not understand why Congress could find money to help providers but not to meet their increasing prescription drug needs. We, therefore, would strongly oppose funding for a "give-backs" package prior to agreement on a Medicare improvement package that includes meaningful drug coverage.

Cost Containment

We recognize that strong and effective cost containment measures are a necessary part of a Medicare prescription drug benefit. In order for a drug benefit to be sustainable over the long run, mechanisms must be in place to control the rising costs

of prescription drugs. AARP actively supports solid cost containment methods as long as patient safety and well-being is not compromised and access to prescription drugs is not impeded. We also support the responsible promotion of generic drugs as one effective cost containment tool.

Both the government and the consumer have an important role to play in helping to control costs. Therefore, in early spring, AARP will roll out a national campaign to educate our members and the public at large about the wise use of medications—including generic drugs. We will encourage our members to talk with their doctors and pharmacists and to learn as much as they can about the safe use of medications.

Conclusion

Our members believe that Congress should be able to work across party lines to enact and begin to implement an affordable Medicare drug benefit. We understand the challenges you face in crafting a proposal for a responsible Medicare drug benefit. We pledge to you that we will provide assistance in every way we can to work with members on both sides of the aisle and to promote a meaningful and broadly supported Medicare prescription drug benefit. We also know that our members will not accept failure or delay. The needs of older and disabled Americans who lack adequate drug coverage can no longer go unheeded. Now is the time to act.

ADDENDUM

Perceptions of a Medicare Rx Plan Among the Public Aged 45+

Selected Findings

- Eight in ten Americans aged 45 and over favor making prescription drug coverage part of the Medicare system. 67% strongly favor this benefit.
- Almost eight in ten Americans aged 45+ consider providing a Medicare prescription drug benefit to be an extremely or very important priority for the President and Congress.
- A majority of Americans aged 18 to 64, and 48% of Americans aged 65+, favor borrowing from the Medicare Trust Fund surplus to finance a Medicare prescription drug benefit. Lower percentages among all age groups favor borrowing from Social Security Trust Fund surpluses to finance a Medicare prescription drug benefit.
- Respondents aged 65 or older (22%) are less willing than those between the ages of 45 to 64 (29%) to pay a $35 monthly premium for a Medicare prescription drug benefit that has a $200 deductible, pays for 50% of the cost of prescriptions, and has a catastrophic coverage cap of $4,000. Overall, 27% of Americans aged 45+ are willing to pay a $35 monthly premium for this coverage.
- Of the 61% of Americans aged 65+ who identified a premium amount less than $35, one-quarter (or 15% of all respondents aged 65+) said they would pay the $35 premium when asked directly if they would be willing to pay that amount for coverage.
- While 41% of the public aged 45+ would be likely to participate in the above Medicare prescription drug plan, only 33% of those aged 65+ would participate. Almost half (47%) of those aged 45 to 54, and 41% of those 55 to 64, say they would be likely to participate in this plan.
- Americans aged 65+ with prescription drug coverage are less likely to participate in this plan than those without coverage. However, the lack of prescription drug coverage may not be a factor in whether or not a person would participate in this plan since individuals aged 65+ with no coverage are split as to whether they would participate—42% would be likely to participate in this plan while 39% would not be likely to participate.
- The role existing coverage plays in individuals' decision to participate in this plan is complicated by the fact that monthly out of pocket prescription drug expenses are also related to whether or not individuals aged 65+ will accept the plan. Majorities of people aged 65+ (54%) without prescription drug coverage and with current monthly average out of pocket drug expenses of $60 or more are likely to accept the plan.
- Among individuals aged 65+ who have prescription coverage, out of pocket drug expenses are also a factor in whether or not they will accept this plan. Almost four in ten (38%) of those aged 65+ with drug coverage but with current average monthly out of pocket expenses of $60 or more are likely to accept this plan. Only 23% of the 65+ population with drug coverage and monthly out of pocket expenses lower than $60 are likely to accept this plan.

METHODOLOGY

Reed Haldy McIntosh collected the data contained in this survey for AARP through the Market Facts Telenation omnibus survey conducted March 1 through March 3, 2002. All questions in the survey were asked of those aged 45 and over (n=885), with the exception of questions 10 and 11 which were asked of all age groups (18+) in the omnibus (n=2,000). The margin of error for this survey is +/- 3.5 percentage points.

RESPONSES TO QUESTIONS FROM SENATOR LINCOLN

Question 1: The AARP has suggested that Congress should set aside $750 billion over the next ten years for prescription drugs. (Last year we set aside $300 billion over ten years.) How did you arrive at this figure? What should a $750 billion prescription drug benefit look like in terms of premiums, coinsurance rate, and catastrophic coverage?

Answer: We know that none of the plans that have been scored so far have met our members "kitchen table" test. For instance, the plans costing $300 billion offered last year did not find public acceptance. We believe Congress and this Committee should focus on the design of a sustainable benefit that makes sense to beneficiaries and remain flexible as to the projected cost.

We have asked Congress to renew its commitment from last year and to adjust the $300 billion to $350 billion to account for cost increases and the addition of a more costly out year. We are also asking Congress to consider an additional reserve fund of $400 billion—equivalent to the CBO projected ten-year surplus in the Medicare Trust Fund—to ensure that there is room enough in the budget for good policy to drive the number rather than the other way around.

In terms of what a Medicare drug benefit should look like, ultimately, we want an affordable prescription drug benefit in the Medicare program that is available to all beneficiaries. To lay the foundation for a comprehensive benefit, a Medicare prescription drug benefit must include, at a minimum:

- An affordable premium and coinsurance;
- A limit on out-of-pocket costs;
- Additional assistance outside of Medicare for low-income persons; and
- Quality and safety features to curb unnecessary costs and prevent dangerous drug interactions.

It is clear that the beneficiary premium associated with a $300 billion package—about $50 a month—is considered too expensive by most beneficiaries. Recent polling data also indicates that many seniors would not accept premiums above $35 a month.

The average Medicare beneficiary is going to take what we call the "kitchen table test." They will look at a prescription drug benefit and ask, "What am I getting for my dollar? As we proceed through the budget process, we will have a better idea of the how much money will be available for a drug benefit and whether it's enough to begin building a benefit that people see as providing value and are willing to pay for.

Question 2: I understand that your organization has done considerable research on the needs and expectations of seniors in terms of a prescriptions drug benefit. Can you explain to the Committee what that research shows? What exactly do most seniors expect in the way of a Medicare drug benefit?

Answer: We have attached a copy of the most recent survey that we conducted. One of the most interesting findings is that eight in ten Americans aged 45 and over favor making prescription drug coverage part of the Medicare system. 67% strongly favor this benefit. Respondents aged 65 or older (22%) are less willing than those between the ages of 45 to 64 (29%) to pay a $35 monthly premium for a Medicare prescription drug benefit that has a $200 deductible, pays for 50% of the cost of prescriptions, and has a catastrophic cap of $4,000. Overall, 27% of Americans aged 45+ are willing to pay a $35 monthly premium for this coverage.

Question 3: As you know, Congress is hearing a lot from the provider community about upcoming cuts and other decreases in payments under Medicare—prompting concerns form some beneficiary advocates about the possibility of another round of "givebacks" this year. In your letter to Senator Conrad dated February 26th, you stated that AARP strongly opposes funding for Medicare "givebacks" prior to an agreement on a meaningful Medicare Improvement package that includes prescription drug coverage. Can you clarify and elaborate on AARP's position on givebacks for the Committee? What constitutes "givebacks"? What is a meaningful package?

Answer: AARP has always supported fair payment for providers who serve Medicare beneficiaries and we want any errors and miscalculations in Medicare payment

that unfairly penalize providers to be fixed. But we must make sure that a Medicare Rx benefit is not delayed another year.

Every dollar for a package of additional provider reimbursements means one dollar less for a Medicare drug benefit. And any giveback package that increases Medicare Part B spending will increase beneficiary premiums because monthly premiums represent 25 percent of Part B costs.

In terms of what constitutes a meaningful prescription drug package—we believe that to lay the foundation for a comprehensive benefit, a Medicare prescription drug benefit must include, at a minimum:

- An affordable premium and coinsurance;
- A limit on out-of-pocket costs;
- Additional assistance outside of Medicare for low-income persons; and
- Quality and safety features to curb unnecessary costs and prevent dangerous drug interactions.

PREPARED STATEMENT OF THOMAS A. SCULLY

Chairman Baucus, Senator Grassley, distinguished Committee members, thank you for inviting me to discuss our new proposal for strengthening Medicare, including prescription drug coverage. Joining me today, Mr. Chairman, is Assistant Secretary for Planning and Evaluation, Bobby Jindal. Bobby has spent a considerable amount of time looking into Medicare reform. As many of you will recall, Bobby served as the Executive Director of National Bipartisan Commission on the Future of Medicare. Strengthening Medicare with prescription drug coverage is one of President Bush's top legislative goals for the year. Since I took this job last June, I have started almost every speech and ended every speech by saying, "Don't let anyone tell you that the Medicare prescription drug benefit can't get through this year. And don't let anyone tell you that we can't address health insurance access this year." For the past twenty years, I have heard that almost every year. I've heard that Medicare reform and prescription drug coverage can't be done—usually because it is an election year and it is too dicey. But I know, and I'm sure you'll agree with me, that a Medicare prescription drug benefit can and should be started this year. My first job in the first Bush Administration in the spring of 1989 was (along with many on this committee) to try to save catastrophic coverage (prescription drugs) for seniors. Congress passed a provision that included drug coverage in 1988, and then repealed it in 1989. And Congress has been debating the need for prescription drug coverage on and off ever since. The bottom line is that seniors, particularly low-income seniors, need prescription drug coverage now—it's long overdue.

We can have a healthy debate about how much additional funding is necessary over the next decade to modernize Medicare—whether it's the $190 billion proposed by the Administration, the $300 billion that had strong bipartisan support in last year's budget resolution, or some other figure. But the problem is that similar numbers have been kicked around for the past 15 years with no action. We believe that $190 billion is sufficient, as part of legislation that brings other aspects of Medicare up to date—including reliable, less costly health care coverage options, an improved benefit package, and lower drug prices through competition. These steps will help seniors not only through a meaningful drug benefit, but also through allowing them to spend their prescription drug dollars more effectively and avoid unnecessary health care costs. We believe that any new spending for Medicare should go toward helping beneficiaries through prescription drugs and better health care coverage options. We must also be cognizant of the fact that most seniors have drug coverage today and many are satisfied with the private coverage they have now—we must avoid "crowding out" good employer coverage. And finally, we must make sure that the prescription drug benefit we implement will be there for seniors in the Baby Boom. The key, however, is *getting started*, and we intend to continue to work closely with Congress to implement a prescription drug benefit that Republicans and Democrats can support.

Senator Graham, Chairman Thomas and others have developed a variety of Medicare reform proposals, but it will take at least several years to get a comprehensive drug benefit set up. But seniors need help now, and there are proposals, like the drug card, and low-income subsidies, that we can do to help seniors immediately as part of comprehensive legislation. This Administration—without a doubt—is committed to Medicare reform and committed to providing a meaningful prescription drug benefit for America's seniors and people with disabilities, and to beginning to provide assistance immediately.

The President, the Secretary, and I are determined to get started now. The President's FY 2003 budget demonstrates the Administration's commitment to modernizing Medicare by dedicating $190 billion over ten years for comprehensive Medicare modernization, including a subsidized prescription drug benefit, better insurance protection, and better private options for all beneficiaries, as well as targeted improvements that begin providing relief immediately. And it is our goal to work constructively with Congress to achieve the President's principles for Medicare legislation, as he announced last July. To that end, I want to discuss with you in greater detail the new proposals to be included in legislation to modernize Medicare, as set forth in the President's budget: the prescription drug card, the transitional low-income drug benefit, and immediate steps to help make sure that seniors who prefer private health insurance coverage in Medicare can continue to get it. The Administration is committed to working with Congress to implement these important changes.

PRESCRIPTION DRUG CARD

The lack of drug coverage among American seniors is becoming a social epidemic and is Medicare's most pressing challenge. Ten million Medicare beneficiaries have no prescription drug coverage at all. About forty percent of these beneficiaries, or 4 million, had incomes below 150 percent of poverty, or an annual income of about $18,000 for a family of two. In fact, Medicare beneficiaries, and the uninsured, are the only people in America today that commonly have to pay full price for prescription drugs. That is simply unacceptable and we must do something to address it. Last year, the President took the first step when he proposed the creation of a new Medicare-endorsed drug card program. The drug card is not a drug benefit and it is not a substitute for one. It is, however, an important first step in helping seniors afford the drugs they need today.

The President's proposal is pretty straightforward—it's a pooling mechanism modeled on private health insurance programs, where consumers routinely benefit from discounts of 10 to 35 percent. Private insurers, with their large numbers of customers, use their market power to secure significant rebates and discounts from manufacturers. In fact, I would venture to guess that all of us in this room, and certainly all federal employees, benefit from lower drug prices as a result of such pooling. Under the President's proposal, Medicare would endorse private drug cards that met minimum standards, allowing seniors to get the information they need to obtain manufacturer discounts and other valuable pharmacy services. These third-party plans will negotiate discounts and rebates directly from drug manufacturers and pass the savings on to Medicare beneficiaries who choose to participate.

One of the strongest arguments for the drug card is that it is the building block for most Medicare prescription drug benefit proposals. For example, both Senator Graham's proposal and Chairman Thomas' proposal both get a significant portion of their savings from pooling seniors into PBMs.

Under the President's drug card proposal, beginning later this year, Medicare would annually endorse a number of discount card options operated by private organizations that meet certain qualifications, including financial stability, accessibility, availability of discounts and other customer service features. Each of the card programs could use formularies, patient education, pharmacy networks, and other commonly used tools to secure deeper discounts for beneficiaries. Medicare beneficiaries could choose the one card that best suits their prescription needs, and at most they would pay an enrollment fee of no more than $25. Beneficiaries would enroll with one particular card for six months at a time, but as their prescription needs change, they could switch cards as frequently as every six months to ensure they are getting the best discounts on their prescriptions and the best pharmacy services. Card sponsors would negotiate discounts with drug manufacturers, and endorsed cards would be required to provide comparable information to beneficiaries about the discounts and other services they offer. The Medicare program would encourage competition among cards through better information, and would simplify Medicare beneficiaries' decisionmaking, by requiring that comparisons of the drug discounts available through the different cards are published and available to beneficiaries. Is this a new benefit? No. Is it perfect? No. But it is a key component to getting on track to implement a prescription drug benefit effectively.

The drug card has another important aspect: CMS has to implement it, just as it will eventually have to implement a more comprehensive drug coverage benefit. CMS knows how to pay hospitals and doctors and nursing homes, but CMS has no experience in working with PBMs, paying pharmacists, or negotiating with drug manufacturers to run a retail drug insurance program. The infrastructure created by the voluntary drug card program and the experience CMS will gain by admin-

istering such a program will be a significant advantage when Congress passes a comprehensive Medicare prescription drug benefit, and CMS has to administer it. In our extensive discussions with AARP, I have found that this may be the top reason for their solid support of this concept—the desire to build the infrastructure and develop the experience needed for an effective Medicare drug benefit.

TRANSITIONAL MEDICARE LOW-INCOME DRUG ASSISTANCE PROGRAM

We've been debating how to cover prescription drugs under Medicare for years. In the absence of a Medicare prescription drug benefit, many states have taken action to assist the neediest seniors. The lowest-income seniors have received prescription drug coverage under the Medicaid dual-eligible program. In addition, 24 states have set up additional prescription drug assistance programs for seniors. Yet many lower-income seniors still get no help. The President believes that comprehensive Medicare legislation should take advantage of existing state infrastructure immediately, and support the integration of existing state low-income programs into the new Medicare drug benefit, by helping states provide drug coverage for low-income seniors right away.

The Administration has proposed to provide immediate support for comprehensive drug coverage for Medicare beneficiaries up to 150% of poverty—about $18,000 for a family of two. This proposal, called the Transitional Medicare Low-Income Drug Assistance Program, would begin by using the existing administrative structure operated by the states (in cases where states have already set up drug assistance programs) and would also allow states to use the new Medicare drug card infrastructure to provide low-income assistance. For Medicare beneficiaries up to 100% of poverty, the program would pay for expanded drug-only coverage at current Medicaid matching rates, much like existing programs that subsidize Medicare premiums and cost-sharing for low-income Medicare beneficiaries. As an incentive for States to expand coverage up to 150% percent of poverty, Medicare would pay 90 percent of the States' cost of drug-only coverage expansion for above 100% of poverty, leaving states responsible for covering the remaining 10%. This policy is projected to expand drug coverage for up to 3 million beneficiaries who currently do not have prescription drug assistance. It would be fully integrated with the Medicare drug benefit once the reform Medicare program is implemented, through a transitional mechanism as envisioned in all major Medicare drug benefit proposals. In addition, to make expanded drug coverage immediately available even before the enactment of the Transitional Low-Income Drug Assistance Program, states can immediately participate in a model drug waiver program called Pharmacy Plus that can cover Medicare beneficiaries up to 200% of poverty. In Illinois, for example, 368,000 additional low-income Medicare beneficiaries, up to 200% of poverty, will receive drug coverage under the waiver we approved last month.

REFORMED MEDICARE WITH PRESCRIPTION DRUG COVERAGE

Medicare—which will spend over $255 billion in 2003 on health care for about 40 million beneficiaries—was established in 1965 to address the national problem of health care for the elderly, and later, citizens with disabilities. Yet, while the private health insurance market has continued to make dramatic advancements to update coverage and improve health outcomes over the past four decades, Medicare has lagged behind. The President believes very strongly that the largely 1965 model of Medicare must be strengthened. I don't think anyone in this room—Democrat, Republican or Independent—if we could start from scratch, would take $255 billion and design the Medicare program we have today. We must work together and finally take action to strengthen the Medicare system and update its outdated benefits package. To this end, the President last year proposed a framework for modernizing and improving the Medicare program that builds on many ideas developed in this Committee and by other Members of Congress. That framework includes the following eight principles:

- All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.
- Modernized Medicare should provide better coverage for preventive care and serious illness.
- Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.
- Medicare should make available better health insurance options, like those available to all Federal employees.
- Medicare legislation should strengthen the program's long-term financial security.

- The management of the government Medicare plan should be strengthened to improve care for seniors.
- Medicare's regulations and administrative procedures should be updated and streamlined, while instances of fraud and abuse should be reduced.
- Medicare should encourage high-quality health care for all seniors.

We all know that when it comes to Medicare reform, even the smallest, most incremental changes can be contentious. But we must get started now, even if it is a gradual but systematic, multi-year approach. Let me assure you that the Administration remains committed to the principles outlined in the framework introduced last year.

There are, of course, a number of things to consider. For example, Congress will have to consider whether the program will be run through private or public entities. It could be administered through private sector risk-bearing contractors (as Medicare+Choice is managed) or through the government-run, fee-for-service Medicare program, where the government bears the risk, not our contractors. All of these questions are extremely difficult. The Administration obviously has strong preferences toward the private sector risk model. We want to work out a long-term solution for seniors. Still, the Administration is determined not to add a new drug benefit to Medicare without significant reform of the program's existing structure.

In this year's budget, the President also made some specific proposals that can be implemented along with this legislative framework to provide immediate assistance to seniors.

RELIABLE, AFFORDABLE, HEALTH INSURANCE COVERAGE OPTIONS IN MEDICARE

The President's framework for strengthening Medicare calls for a fair payment system for private plan options for Medicare beneficiaries, like the system that provides reliable health insurance options to all Federal employees in the Federal Employees Health Benefits program. Private plans have long been the preferred choice of 6 million Medicare beneficiaries. This is not surprising, because the private plans allow beneficiaries to receive more up-to-date benefits than are available under traditional Medicare. The enhanced benefits can include prescription drugs, disease management programs, and better preventive care services—benefits widely available to the nonelderly and to members of Congress. Frequently, private plans have provided much lower cost sharing for required Medicare benefits as well.

Action is needed now to ensure that these benefits remain available to Medicare beneficiaries, because the current Medicare+Choice system for paying private plans is not giving beneficiaries the options they deserve. Since the new payment system was implemented in 1998, hundreds of Medicare+Choice organizations have left the program or reduced their service areas, adversely affecting coverage for hundreds of thousands of beneficiaries—reversing what had been an upward trend in private plan availability and enrollment. In addition, the remaining plans are offering less generous drug benefits and other coverage. Moreover, open-network plans like Preferred Provider Organizations (PPOs) and point of service plans have become popular among privately covered individuals, yet only two PPOs participate in a few counties in the entire Medicare program.

Annual increases in Medicare+Choice funding have failed to reflect rising health care costs, leading to unreliable options and reduced benefits for seniors. Specifically, between 1998–2002, Medicare+Choice rates increased at 2 or 3 percent per year, or only 11.5 percent overall, in counties where the majority of Medicare+Choice enrollees live. This compares with increases in Medicare fee-for-service (government) plan spending by over 21 percent and medical cost inflation of 9 to 10 percent per year and the same time period. Because payments to private plans do not reflect conditions in Medicare and the health care marketplace, private health plans are struggling to maintain benefit levels.

The President's budget proposes to take urgently needed steps toward the equitable payment system for private plans proposed in the President's framework for strengthening Medicare. The proposal will modify the Medicare+Choice payment formula to better reflect actual health care cost increase and allocate additional resources in 2003 to counties that have received only minimum updates over the last few years. This would make it possible for more private plans to remain in Medicare until the new payment system is phased in. Proposals to help sustain private plans in Medicare are supported by both Democrats and Republicans.

Under the President's proposal, all plans will receive payment increases equivalent to national fee-for-service cost growth minus 0.5 percent. For 2003, plans in counties that have been receiving the minimum updates (2 to 3 percent) will receive a 6.5 percent increase in payments. The budget also proposes incentive payments for new types of plans that enter Medicare+Choice to encourage a variety of new

managed care plans (e.g., PPOs) to participate in Medicare+Choice. The augmented payments to improve beneficiaries' options would cost $390 million between 2003–05 and would increase Medicare+Choice enrollment by more than 7% by 2007.

As a further immediate step that can be implemented to begin to improve benefits in comprehensive legislation, the President's budget expands on his proposal for improving the Medicare benefit package and for making it more affordable by proposing that two new Medigap plans be added to the existing 10. The new Medigap plans would offer prescription drug coverage, protect beneficiaries against catastrophic illness and include modest beneficiary cost sharing at a more affordable cost than the most popular current Medigap plans.

Medigap reform is important to the overall Medicare reform because two-thirds of seniors rely on individual or employer-sponsored supplemental plans. Most covered seniors do not understand the difference between their $54 monthly Medicare premium and their monthly Medigap premium. The many non-poor seniors who can afford a Medigap policy have no option under the current Medigap structure that allows them to get the protection they need from high costs while avoiding the incentives for excess utilization resulting from first-dollar wraparound coverage. Once they send in their Medigap premium, costs are out of their hands.

Private health plans generally have better preventive benefits and better stop-loss protection than Medicare's benefit package, and all also include some kind of cost-sharing to encourage efficient care utilization. A key, then, to funding a significant prescription drug benefit is to include modest incentives for beneficiaries to utilize the rest of the Medicare program more efficiently, while allowing them to get the protection they need at a lower cost, freeing existing Medicare beneficiary and program dollars to help pay for prescription drugs. Therefore, any new Medicare prescription drug benefit should be added only in the context of improvements in the traditional Medicare fee-for-service benefit package, as well as in an improved Medicare+Choice model. Of course, as the President has made clear, seniors should be able to keep their existing Medicare coverage with no changes if they prefer it. Seniors need a drug benefit, and good prescription drug coverage requires an improved and modernized Medicare program.

CONCLUSION

Four years ago, Washington's bipartisan efforts to reform Medicare stalled out over a 10–6 logjam of the Medicare Commission. Last year, there was a serious bipartisan effort to improve Medicare with prescription drug coverage. This included a budget resolution with strong bipartisan support, to set aside substantial funding for a prescription drug benefit and other overdue improvements in Medicare. It also included detailed work and discussions in both the House and the Senate to develop legislation for the fall. But the extraordinary events of September 11th delayed Congressional action on this top legislative priority. President Bush is determined to work with Congress to get that process moving again, and he has started the process by reaffirming his commitment to devoting substantial new resources to Medicare and to his framework for Medicare legislation. He has also proposed a number of steps that can be implemented with modernization legislation that will provide immediate relief to seniors and help implement the drug benefit and other coverage improvements more effectively. This Administration understands that Members of Congress have a lot of strong views regarding Medicare reform, and we are open to any and all ideas as long as they move the debate forward. The one option, however, that is completely unacceptable to the Administration is the status quo. The Administration is determined to work with Congress to get a prescription drug benefit enacted this year. In addition, we are determined to begin to offer seniors some relief immediately through administrative actions like the drug card and the Medicaid Pharmacy Plus waiver program. Thank you for the opportunity to discuss this very important topic with you today. I hope that I have been able to express the Administration's dedication to strengthening Medicare, as well as our commitment to work with you to do so. I look forward to answering your questions.

PREPARED STATEMENT OF HON. CRAIG THOMAS

Today, the Finance Committee is hearing testimony on proposals to assist seniors with the high cost of prescription drugs and Medicare programmatic reforms. I commend the Chairman and Ranking Member for providing this opportunity to discuss these issues.

Prescription drugs have become the cornerstone of modern medicine. However, the escalation in drug costs and the fact that many seniors have multiple prescriptions, leave a significant number of our nation's elderly struggling to pay for their medi-

cines and make ends meet. There is no question that the Medicare program is antiquated by not providing a prescription drug benefit. However, given the current budget constraints and future dire predications of Medicare insolvency, it is critically important that we act prudently.

In terms of restructuring the Medicare program it is crucial that this Committee address the needs of rural providers. Rural providers have historically gotten the "short end of the stick" because of the misconception that health care is cheaper in rural areas. While, there are slight differences in labor costs across the country, health care is not cheaper in rural America. Drug companies, technology companies and medical supply companies do not sell their products to rural providers at lower rates simply because of geography. Rural providers face different economies of scale due to their lower volume and it is time the Medicare program recognize the unique circumstances of these providers. In addition, seniors make up a larger proportion of this country's rural population, which causes providers to be extremely vulnerable to changes in Medicare payment policies. Compliance with federal regulations are also especially burdensome for rural providers as most do not have regulatory technical expertise or access to a consultant.

In closing, I wish to remind my colleagues that simply passing a prescription drug benefit for political points does none of us any good if it causes the Medicare program to spiral into insolvency. As United States Senators we have a responsibility to represent our constituents, we also have the duty to consider the needs of future generations.

COMMUNICATIONS

STATEMENT OF THE ALLIANCE FOR RETIRED AMERICANS

Chairman Baucus and Members of the Finance Committee, the Alliance for Retired Americans commends you for holding this hearing today on the Administration's proposals to revise and restructure the Medicare program.

The Alliance is national organization of over 2.5 million members that works to create an America that protects the health and economic security of seniors, rewards work, strengthens families and builds thriving communities. It was launched in January 2001 by a national coalition of labor unions and community-based organizations dedicated to improving the quality of life for retirees and older Americans.

The stability of the Medicare system is a core concern of the Alliance and is critical to our mission to strengthen the quality of life for older Americans. We believe the establishment of a universal, voluntary, and comprehensive Medicare prescription drug benefit program is essential for the well being of America's seniors. We appreciate the opportunity to comment on the Administration's proposals and to offer our recommendations.

The Fiscal Year 2003 Budget Proposal

The Administration's $190 billion proposal for Medicare changes, including a paltry $77 billion for a very limited prescription drug benefit program, is an affront to America's seniors. The need for a comprehensive program is already abundantly clear. Without such a benefit, Medicare fails the test of being a complete comprehensive health insurance system. Our members tell us every day how rising drug costs force them to make terrible decisions regarding buying drugs or food, paying the mortgage or rent, or simply going without. Often this has resulted in even more terrible health consequences.

We all know Americans pay the highest prescription drug prices in the world. America's seniors are predicted to spend $1.5 trillion on prescription drug costs during the next ten years. The prescription drug inflation rate is in double digits every year. Since older Americans use prescription drugs more than any other segment of the population, the rising costs are a threat to the economic and health security of Alliance members and other older Americans. We need action now on the Medicare prescription drug issue.

The proposed FY 2003 does not remotely offer the relief America's seniors need. The documents accompanying the Administration's budget state that the President believes the nation has a "moral obligation" to fulfill the promise of health care security for America's seniors and people with disabilities under Medicare. Furthermore, the first principle for legislation in the Administration's budget documents states "all seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare." Unfortunately, the FY 2003 budget falls far short of those stated goals. The $190 billion proposal for all Medicare reforms is well below the FY 2002 Budget Resolution that contained a $300 billion reserve fund for a Medicare prescription drug benefit program. The Alliance believes that the $300 billion reserve is inadequate for a universal Medicare prescription drug benefit program. Needless to say, the current proposal of $190 billion is a major step backwards.

Under the President's proposal, only 3 in 10 seniors who currently need coverage would receive some benefit. Middle-income seniors are completely left out of coverage. An individual with an annual income above $12,885 or a couple earning over $17,415 would receive no help under the Administration's plan. These are not wealthy Americans. They are Americans who worked all their lives only to see the costs of prescription drugs threaten their retirement security. Clearly, the Administration's proposals are inadequate on their face at a time when older Americans are seeing double-digit inflation in their drug prices every year.

The proposed delivery system will not work. First, only $8 billion of the $77 billion proposed for prescription drugs would be available between now and FY 2006. Secondly, the FY 2003 budget proposes that the states administer the plan through the Medicaid systems. States would first have cover recipients to 100% of the poverty level in order to become eligible for the new proposed subsidy. Many states are not at that level of coverage. At a time when the states are facing fiscal crises, there is a high likelihood that many states will not choose to participate. The Administration's proposal places an unnecessary and potentially permanent barrier between American's seniors and their ability to obtain more affordable prescription drugs. Finally, running the program as a welfare benefit for seniors is another affront to them. This proposal wrongly mixes the Medicare and Medicaid programs. The Alliance urges Congress to reject it.

In addition to the budget proposal, the Administration announced on February 28, 2002 its intention to proceed with a prescription discount card program. Under this plan, pharmacy benefit managers (PBMs) would decide which drugs would be covered for discounts and then negotiate for discounts with pharmaceutical companies. However, the PBMs make more money off brand name drugs rather than generic drugs and they can control which drugs get the discounts. Seniors, who would have to pay a one-time $25 fee, would not be guaranteed that the drugs their doctors prescribe would be eligible for any discount. The Department of Health and Human Services would also give a government endorsement to PBMs that participate in the program. Surely this proposal cannot be seen as fulfilling the Administration's principle that all seniors have the option of a subsidized prescription drug benefit. There is no guarantee of any savings at all. The Alliance opposes schemes like this one, which takes away attention from the rising costs of drugs and the immediate need to enact a comprehensive Medicare prescription drug benefit program. The General Accounting Office released a report in January concluded that discount card programs in fact provide little, if any, relief to seniors from the burden of the high costs of prescription drugs.

Alliance Proposals for Medicare Prescription Drug Benefits

The Alliance urges Congress to honor its commitment to enact a universal, affordable Medicare prescription drug benefit. Congress agreed to a prescription drug program as a high legislative priority when it created the $300 billion reserve fund in the FY 2002 Budget Resolution. While that funding level is inadequate for a universal program, the Alliance has developed a set of principles for a comprehensive program.

A comprehensive Medicare prescription drug benefit would provide full, and affordable access to all medically necessary medications. It should include an indexed monthly premium beginning in the $20–$25 range, a 20 percent co-insurance of prescription costs, a $100 deductible, and a $2,000 out-of-pocket cap. The Alliance believes a program should include incentives to employers to maintain retiree prescription benefits. Such a program would not authorize insurance and pharmaceutical benefit management companies, which are engaged to administer the benefit, to create restrictive formularies nor would it limit purchases to authorized pharmacies only.

The administration of such a Medicare prescription drug benefit program, designed to be voluntary and universal, would include a public process of ongoing evaluation and annual reports regarding the efficiency of the program. Such evaluations would include recommendations for Congress to take in order to moderate or reduce the costs of pharmaceuticals for Medicare beneficiaries and others.

Mr. Chairman and Members of the Committee, the Alliance for Retired Americans believes that now is the time to begin the process of establishing a universal Medicare prescription drug benefit program. Each year more and more seniors find their drug costs soaring beyond their means. Today's seniors are a generation that sacrificed much in order to build modern America. Remember that it was during the early days of World War II when beneficiaries began to receive the first Social Security checks in great numbers and the Medicare program began at the height of the Vietnam conflict. There is no reason to shy away from the present urgent need: the creation of a universal Medicare prescription drug program. The Alliance believes that delay is not an option.

Thank you.

STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS–AMERICAN SOCIETY OF INTERNAL MEDICINE

The American College of Physicians-American Society of Internal Medicine (ACP–ASIM)—representing 115,000 physicians and medical students—is the largest medical specialty society and the second largest medical organization in the United States. Internists provide care for more Medicare patients than any other medical specialty. We congratulate the Committee on Finance for holding this important hearing to address President George W. Bush's proposals for Medicare modernization. ACP–ASIM thanks Senator Max Baucus, chair of the Committee, Senator Charles E. Grassley, the ranking member of the Committee, and other committee members for convening this important hearing.

President Bush's Fiscal Year 2003 budget proposes many important first steps in reforming the Medicare program. The budget proposed to spend $190 billion over ten years for improving the Medicare program. A prescription drug program would receive $77 billion to help states cover prescription drugs for Medicare beneficiaries between 100 and 150 percent of poverty. The remaining $113 billion would be used to overhaul the Medicare plan and provide a universal drug benefit.

ACP–ASIM is pleased that the budget summary acknowledges the problems caused by constant changes in Medicare physician payments and expresses the administration's willingness to work with Congress to fix the problem, both short and long term. However, we are concerned that the President's budget does not provide any relief for teaching hospitals from scheduled budget cuts. Instead, the budget proposed further unspecified cuts of $570 million over ten years in Medicare funding for the indirect costs of graduate medical education.

BACKGROUND

Medicare's enduring success as a program has been predicated on its promise of coverage for all elderly and disabled persons, regardless of income. Because virtually all Americans anticipate that they will someday be eligible for Medicare, the program has enjoyed sustained political support from voters. Such support has proven to be a critical factor in assuring a sufficient commitment of funds from Congress to finance the program.

Medicare's success has also been a function of the unparalleled choice and availability of physicians and health care services that it offers beneficiaries. Today, most private sector health insurance plans restrict enrollees to a pre-selected panel of providers. By contrast, under the traditional fee-for-service program, Medicare patients are permitted to obtain care from any health care provider who is willing to see them. (Even beneficiaries who opt to enroll in Medicare+Choice managed care plans have had the ability to rejoin the fee-for-service program, with its virtually unlimited choice of physicians, anytime during a calendar year). Participation of physicians and other health care providers in the traditional Medicare fee-for-service program historically has been extraordinarily high, due in large part to reimbursement rates that made it economically attractive for them to participate in the program.

By contrast, the Medicaid program—the sister program created by Congress in 1965 to provide access to care for poorer Americans—has fared far less when compared to Medicare. As a means-tested program, it has not had the broad political support needed to sustain its financing. Low Medicaid reimbursement rates have led to low levels of participation by physicians and other providers. Medicaid patients typically have far less choice of physicians and other health care providers than Medicare beneficiaries. The research literature on Medicaid is rife with evidence on the difficulties encountered by enrollees in accessing needed care.

Unfortunately, there is reason to believe that Medicare is becoming more like Medicaid. *In the absence of legislation to reform the program, Medicare is on the verge of becoming a chronically under-funded program, one which offers limited choice of providers and reduced access.*

Medicare also faces other threats. *It has suffered from a program management mindset that emphasizes micromanagement and sanctions over innovation and collaboration*. Excessive regulation diverts resources from patient care, drives up the compliance costs incurred by health care professionals, and discourages provider participation in the program. *Medicare's outdated benefit structure excludes coverage for essential life-saving medications and preventive/screening services. Medicare's financing structure, which relies on payroll taxes, premium contributions and general revenue, is likely to be inadequate to assure continued access to care*, particularly as the "baby boom" generation becomes Medicare-eligible and the costs of care continue to rise.

Over the past several years, ACP–ASIM has developed a series of position papers that diagnose Medicare's ills-inadequate reimbursement for existing services, excessive regulation, outdated benefits, and a financing structure that will be insufficient to meet the challenges of an aging population and rising health care costs. Based on those position papers, America's internists today are proposing a plan of treatment to cure Medicare's ills. Further explanation of the College's diagnoses and policy prescriptions can be found in the more detailed position papers.

MEDICARE REIMBURSEMENT TO PHYSICIANS AND TEACHING HOSPITALS

Medicare suffers from declining reimbursement rates that threaten patients' access to care. Beginning January 1, 2002, Medicare reimbursement payments to physicians and other health care professionals fell an average of 5.4 percent. The Centers for Medicare and Medicaid Services (CMS) projects that payments for physician services will continue to decline for at least the next three years. As illustrated in the attached chart, Medicare payments will continue to fall behind the increased costs of delivering services over the 2002–2005 calendar period:

2002: On January 1, Medicare payments for physician services were cut by 5.4 percent before inflation; 8.2 percent after inflation*.

2003: Medicare payments for physician services are projected to be cut by 10.8 percent before inflation and 16.2 percent after inflation* (relative to 2001).

2004: Medicare payments for physician services are projected to be cut by 15.9 percent before inflation and 23.5 percent after inflation* (relative to 2001).

2005: Medicare payments for physician services are projected to be cut by 18.3 percent before inflation and 28.1 percent after inflation* (relative to 2001).

*Note: The above assumes a very conservative annual inflation rate in the costs of providing services of 3 percent per year over the 2002–2005 period. Actual inflation increases in the costs of providing services are likely to be higher. Therefore, the above estimates likely *understate* the magnitude of the anticipated cuts after increases in the costs of providing services are taken into account.

The problem of payment reductions that are falling below increases in the costs of providing services is not one that was created overnight. Congress adopted the current physician payment methodology for updating annual payments (known as the Sustainable Growth Rate or SGR) in the Balanced Budget Act of 1997. Even then, ACP–ASIM recognized the serious flaws inherent in the SGR payment system and voiced our concern. Congress attempted to make corrections to the payment formula in 1999 with the Balanced Budget Refinement Act; however, it was not sufficient enough to correct the intrinsic problems. The economic downturn the country is now facing has only exacerbated the problem. The SGR system errantly ties physician payment to the Gross Domestic Product (GDP). There is no other segment of the health care industry that uses such a methodology to update payment. This method of tying physician payment to the health of the overall economy bears absolutely no relation to the cost of providing actual physician services. In the years where the economy is facing a downturn, such as today, massive cuts in payments for physician services' can be triggered.

In its March 2002 report to the Congress, the Medicare Payment Advisory Commission (MedPAC) expresses grave concern about the underlying problem of tying the SGR to the economy. MedPAC states that the current SGR system may even cause payments to deviate from physician costs because it does not fully account for factors affecting the actual cost of providing services, and recommends that Congress replace the SGR with a new framework, based on input prices for physician services adjusted for productivity gains.

Physicians have a strong sense of commitment to their Medicare patients. They will do everything within reason to continue to provide their Medicare patients with high quality, accessible health care, even in the face of rising costs and declining reimbursement. *However, there is a point where the economics of running a practice will force physicians to institute changes to limit the damage from continued Medicare payment cuts*. Like any small business, revenue must exceed the costs of providing services in order for a practice to remain financially viable. Physicians will have essentially only four options available to them to offset the losses from declining Medicare payments and rising costs. They can reduce their reliance on Medicare revenue, by restructuring their practices to decrease the share of their practice revenue that comes from Medicare, while increasing the share that comes from more reliable (non-Medicare) payers. This would be accomplished by putting limits on how many Medicare patients will be seen while marketing the practice to non-Medicare populations. They can cut costs—eliminating beneficial services and technology. They can do both: cut beneficial services *and* reduce their reliance on Medicare. Or they can go out of business, by closing their practices entirely.

Physician services are not the only provider area that has been subjected to deep Medicare payment cuts. Teaching hospitals, home health agencies, hospitals, and other providers are also facing cuts. Under-funding of these other Medicare benefits also poses a long-term threat to the program. No other area of provider reimbursement, however, will be cut by almost 30 percent (in constant 2001 dollars) over the 2002–2005 period. Therefore, the highest priority should go toward halting the cuts in payments for physician services and, secondly, averting continued cuts in payments for key "safety net" providers, particularly teaching hospitals that provide a large proportion of indigent care.

Congress should assure that payments are sufficient to assure continued access to existing Medicare benefits. Specifically:

1. Congress should halt the 5.4% cut in 2002 payments for physician services.
2. Congress should enact MedPAC's recommendation to eliminate the SGR and replace it with an update framework based on changes in physicians' input prices, with adjustments for productivity and other factors that affect the cost of, and access to, care.
3. Congress should also include a default formula to establish the update, based on the Medicare economic index (MEI) minus a .5% productivity adjustment, in years when Congress chooses not to act to establish an update based on the MedPAC update recommendation.
4. Congress should also set the CY 2003 update at the MEI minus a .5% adjustment factor. (This change is necessary to assure that payments next year keep pace with increased costs, as the new MedPAC framework is being implemented).
5. Congress should halt further reductions in indirect medical education payments to teaching hospitals.

REDUCING REGULATORY BURDENS

Medicare suffers from a management approach that has emphasized excessive regulation and paperwork, rather than strategies that encourage innovations in service delivery to lower costs and enhance quality of care.

The Medicare program has historically relied on audits, documentation, and complex payment rules to control costs. It is impossible for physicians to keep abreast of the vast, ever expanding and ever changing array of Medicare rules, regulations, instructions, and policies—an estimated 100,000 pages of Medicare requirements. This information is disseminated from many sources and is often difficult to accurately comprehend and interpret. The emphasis on excessive documentation, micromanagement and audits diverts physicians' attention away from patient care. Unfunded regulatory mandates, coupled with declining fees, may force physicians to reassess their relationship with Medicare, and thereby, limit their services currently provided for Medicare patients.

Fortunately, progress is being made in easing Medicare hassles and red tape. The House of Representatives unanimously passed a Medicare reform bill in December 2001 that would limit the use of extrapolation (the ability of auditors to examine as few as fifteen records and apply the results to thousands of claims); require Medicare carriers to provide written clarification when requested; require payers to honor those clarifications during audits; require that independent contractor review of denials of services take place before a carrier could demand repayment for services; and use pilot projects to determine alternative ways of documenting evaluation and management (E/M) services. The Department of Health and Human Services has also appointed a new advisory committee on regulatory relief to solicit proposals on changes that the department can make on its own to reduce red tape.

Easing excessive Medicare red tape is not enough, however. The Centers for Medicare and Medicaid Services (CMS) needs to be directed to use innovative approaches to delivering, paying for, and purchasing services that have the potential of reducing costs and improving quality. In a 1997 position paper, ACP–ASIM recommended that Medicare needed to undergo a realignment that would focus on encouraging a more coordinated and comprehensive approach to providing care to Medicare beneficiaries with chronic illnesses. It proposed changes in Medicare payment policies (e.g. expanded bundled payment, contracting with providers for care management and coordinated care of chronic patients, and competitive bidding) and the inclusion of additional covered services (e.g. case management, expanded hospice-type services, and preventive care). The Lewin Group estimated at that time that such changes could save $65 billion over five years. Potential savings today from such methods would need to be recalculated to reflect changes in the program and new budget baseline projections from the Congressional Budget Office; however, the 1997 data suggest that substantial savings from the recommended changes are possible.

Although Congress and the Medicare program have instituted some demonstration projects and program innovations that are consistent with the 1997 proposals from ACP–ASIM, more needs to be done to encourage Medicare to support innovative methods of delivering and paying for medical care and to use its prudent purchasing authority to reduce costs.

Congress and CMS should realign Medicare's management philosophy from one that emphasizes regulation and micromanagement to one that encourages innovation in health care delivery. Specifically:

1. Congress should enact H.R. 3391, the Medicare Regulatory and Contracting Reform Act of 2001.
2. HHS Secretary Thompson's advisory committee on regulatory relief should continue to work with physicians and other health care professionals to institute changes to reduce specific unnecessary regulatory requirements. The task force's emphasis should be expanded to address ways to achieve long-term changes in how CMS approaches the regulatory process, such as by requiring that CMS regularly assess the amount of *time* required by health care providers in complying with regulations in addition to the direct costs of compliance.
3. CMS should be directed, and given the authority to, support innovative programs for health care delivery, including expanded use of case management, disease management, and coordinated services for patients with chronic conditions, bundled payment for selected services, and expanded hospice-like services to terminally ill patients who otherwise would not qualify for hospice benefits.
4. CMS should be directed to use competitive bidding, negotiations, and other prudent purchasing methods to lower prices for equipment and supplies.

PRESCRIPTION DRUG COVERAGE AND MODERNIZATION

Medicare suffers from an outdated benefits package that denies patients access to life-saving medications and preventive/screening services and exposes beneficiaries to catastrophically high out-of-pocket expenses. Medicare beneficiaries are denied access to important life-saving medical services because the existing plan of benefits, which remains fundamentally the same as that which was established when the program was created in 1965, excludes coverage for most prescription drugs and preventive and screening tests. Although Congress has added some preventive services, such as coverage for selected cancer screening tests on a piecemeal basis, the basic requirement for coverage is that the service must be for the *diagnosis and treatment of disease on patients who present themselves with symptoms of disease*. Screening tests on well beneficiaries generally are not covered benefits.

Medicare benefits must be updated to cover needed medications and preventive care. However, the addition of Medicare benefits for preventive services should be based upon evidence of medical effectiveness. The cost-sharing structure also needs to be modified to reduce inequities and to encourage prevention. Currently, cost-sharing for hospital admissions is much higher than for those seeking out-patient physician care. Once a package of preventive and screening procedures is added to Medicare, it will be important to exempt such services from cost-sharing requirements that otherwise would create an economic barrier to obtaining such services. There is no limit on total out-of-pocket expenses that may be incurred by a patient in a calendar year or lifetime. These issues put the Medicare program and its beneficiaries at risk—for poor health and financial disaster.

Ideally, a prescription drug benefit should cover all Medicare beneficiaries equally. However, if a universal benefit carries too large a price tag, then coverage should be targeted to those most in need—low-income beneficiaries, those with high drug costs, and those with multiple chronic diseases. To ensure a high quality of life and to eliminate costly, unnecessary hospitalizations, our most vulnerable Medicare beneficiaries must have access to needed prescription medications. ACP–ASIM supports a number of mechanisms to control the costs of a prescription drug benefit, but with the conditions that patient safety and quality of care should be the primary focus.

Congress should expand Medicare benefits to cover prescription drugs, institute measures to lower the costs of prescription drugs, provide coverage for evidence-based preventive and screening procedures, and modify Medicare's cost-sharing structure to better meet the needs of beneficiaries.

Prescription Drug Coverage

1. The highest priority should go toward providing voluntary prescription drug benefits for those most in need: low income beneficiaries who do not have access to drug coverage under other plans.

2. If sustainable, predictable financing is available, ACP–ASIM supports providing an optional Medicare prescription drug benefit to all beneficiaries, regardless of income and health status.

3. Drug benefit plans should be voluntary, and seniors should be able to opt out of the program and maintain their existing Medicare coverage.

4. The benefit must be financed in such a way as to bring in sufficient revenue to support the costs of the program, both short and long-term, without further threatening the solvency of the Medicare program or requiring cuts in payments for other services or reduced benefits in other areas. ACP–ASIM recommends that Congress consider: (1) increasing general revenues or payroll taxes to support a Medicare prescription drug benefit, and (2) income-related premium contributions, co-payments, and deductibles to support the program.

5. The maximum allowable Medicare reimbursement for prescription drugs should balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products. Rigid price controls that will discourage innovation and threaten drug supply should be rejected. ACP–ASIM supports using prudent-purchasing tools in designing a Medicare prescription drug benefit. Like the VA, Medicare should investigate average wholesale drug prices and directly negotiate with manufacturers or wholesalers.

6. Until the safety concerns issued by the FDA and HHS are resolved, ACP–ASIM opposes prescription drug re-importation as a means to reduce retail drug prices.

7. If therapeutic safety and equivalency are established, then generic drugs should be used, as available, for beneficiaries of a Medicare prescription drug benefit. In order to eliminate delays for generic entry into the market and discourage financial arrangements between generic and name brand manufacturers, Congress should close loopholes in patent protection legislation.

8. ACP–ASIM supports research into the use of evidence-based formularies with a tiered co-payment system and a national drug information system, as a means to safely and effectively reduce the cost of a Medicare prescription drug benefit, while assuring access to needed medications. Demonstration projects to test such methods should be established before a national program is introduced.

9. Medicare prescription drug formularies should not operate to the detriment of patients, such as those developed primarily to control costs. Decisions about which drugs are chosen for formulary inclusion should be based on effectiveness, safety, and ease of administration rather than solely based on cost. Formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically-indicated cause) without cumbersome prior authorization requirements.

10. Medicare prescription drug benefit should not limit coverage to certain therapeutic categories of drugs, or drugs for certain diseases.

11. To counterbalance pharmaceutical manufacturers' direct-to-consumer advertising, ACP–ASIM recommends that insurers, patients and physicians have access to unit price and course of treatment costs for medically equivalent prescription drugs.

12. If pharmacy benefit managers (PBMs) are used to administer a Medicare prescription drug benefit, they should be subject to consumer protection standards of accountability, including:

- Disclosure to patients, physicians, and insurers of the financial relationships between PBMs, pharmacists, and pharmaceutical manufacturers;
- Requiring that PBM requests to alter medication regimes occur only when such requests are based on objective data supported by peer reviewed medical literature and after having undergone review and approval by associated MCO/MBHO Pharmacy and Therapeutics Committees,
- Requiring that, with a patient's consent, PBMs be required to provide treating physicians with all available information about the patient's medication history.

13. ACP–ASIM believes that switching prescription medications to over-the-counter status should be based on clear clinical evidence that an OTC switch would not harm patient safety, through inaccurate self-diagnosis and self-medication, or lead to reduced access to "switched" drugs because they would no longer be covered under a prescription drug benefit. Manufacturers and other interested parties should be allowed to request such a reclassification.

14. ACP–ASIM supports the creation of a Medicare prescription drug card program as a first step to providing seniors assistance with prescription drug costs, provided that:

- The program is not a substitute for comprehensive Medicare prescription drug coverage.
- Pharmacy benefit managers (PBMs) are required to pass on rebates from manufacturers to pharmacies, and subsequently, beneficiaries.
- Program costs for beneficiaries are minimal or free.
- Card sponsors publish complete drug pricing information, so that Medicare recipients can "shop" for the best card.

Evidence-based Preventive and Screening Services

15. Congress should establish a process to authorize coverage of appropriate and cost-effective preventive care and screening services in an ongoing fashion, based on expert evaluation of, and consensus on, the medical evidence of their effectiveness. Medicare payment levels to physicians for covered preventive benefits must be adequate to assure that beneficiaries have access to such services.

16. Congress should authorize coverage for *physician-directed* geriatric assessments and care coordination of frail elderly patients, as defined in S. 775, the Geriatric Care Act of 2001.

Cost-Sharing Requirements and Stop-Loss Coverage

17. Congress should establish a total annual and lifetime limit on out-of-pocket expenses under Medicare for all covered services.

18. Congress should consider combining Medicare Parts A and B with a single deductible, provided that:

- Medicare benefits are expanded to include coverage of preventive and screening procedures, and geriatric care assessments;
- Such specified preventive and screening procedures are not subject to the deductible, and no co-insurance or co-payments would apply;
- A limit is placed on total out-of-pocket expenses that a beneficiary may incur in a calendar year (i.e., stop-loss coverage);
- The single deductible is set at an actuarially appropriate level that does not cause an undue financial burden on beneficiaries, especially lower-income beneficiaries.

MEDICARE PROGRAM SOLVENCY

Medicare suffers from a financing structure that may not be adequate to assure continued solvency as the population ages and as medical care costs continue to rise. Some proposals to fundamentally change the program, however, would unacceptably weaken key strengths of the existing program (i.e., "the cure would be worse than the sickness"). The changes outlined in the previous parts of this statement will help lower costs and improve the quality of patient care. However, additional changes in Medicare financing may be required to assure the continued solvency of the program.

One option is to convert Medicare to a defined *contribution* program. Under a defined contribution program, the federal government would provide each beneficiary with an allowance to purchase a package of benefits in the private sector. The amount of the allowance could be linked to the cost of a package that includes benefits comparable to the current Medicare program, but this would not be guaranteed. Another variation of this approach is a defined *benefit* voucher program. Like a defined contribution, a premium support program would provide beneficiaries with an allowance to purchase coverage in the private sector, but with a *requirement* that the voucher be sufficient to purchase coverage equal to the current Medicare program.

Critics of a defined contribution program argue that it would erode benefits for lower-income beneficiaries, because the federal allowance would be too low for them to afford a plan with comprehensive benefits comparable to the current program. As an alternative, they propose maintaining the current Medicare benefit structure, with increased taxes if necessary to assure continued solvency.

The College has strong practical and philosophical objections to converting Medicare to a defined contribution program. ACP–ASIM has a long-standing history of support for universal coverage. While the Congress has been unable to agree on a program to provide coverage to all Americans, the existence of Medicare has provided coverage for *all elderly and disabled* Americans. A defined contribution program would price many lower-income elderly and disabled Americans out of the market for coverage. It would therefore represent a set back in the drive to expand

coverage to all Americans. On this basis alone, as a matter of principle, ACP–ASIM cannot support conversion of Medicare into a defined contribution program.

ACP–ASIM is particularly concerned about the impact a defined contribution program would have on less wealthy beneficiaries. One of the abiding strengths of the conventional Medicare program is that it provides the same coverage and benefits to beneficiaries, regardless of income or acquired assets. The fact that Medicare is not viewed as a "welfare" program is one of the reasons that it has enjoyed consistent public support. A defined contribution program would create a two-tiered system, with the less wealthy being forced into plans with less coverage and benefits than the plans available to the wealthy. This would not only be unjust, but also politically unwise, since it would undermine public support for the program.

On a practical level, a defined contribution program places too much faith in the ability of frail beneficiaries to "shop" for coverage and make a wise choice among competing plans. The example of the federal employees health benefits program (FEHBP) may not be illustrative of the impact of a similar program on the elderly and disabled, since the federal employee workforce is generally better-educated, younger, and healthier than the Medicare population. The elderly and disabled would be far more vulnerable to abusive marketing practices. They would be at greater risk of purchasing plans that provide inadequate coverage for their medical conditions. The only plans that lower income beneficiaries may be able to afford would be ones with very high deductibles and co-payments, imposing a harsh financial barrier on their access to care.

ACP–ASIM can support, however, a well-designed demonstration project to test the impact of a defined *benefit* voucher program, one which guarantees that the federal contribution will be sufficient to purchase a package of benefits equal to the current program.

Another option for maintaining the continued solvency of Medicare is to postpone the age of eligibility. The argument for postponing eligibility age past 65 is that beneficiaries are living longer than when Medicare is enacted, and that this demographic shift would justify a delay in the age of eligibility. However, ACP–ASIM is concerned that the consequence of such a change, in the absence of a program to provide universal coverage to all Americans, is that the number of uninsured would increase because retirees would no longer have coverage through an employer, but would be ineligible for Medicare for a longer period of time.

Requiring higher-income beneficiaries to pay more into the program has also been advanced as a way of helping to extend the solvency of the program. From a standpoint of fairness, ACP–ASIM agrees that it is appropriate to ask higher income beneficiaries to contribute a greater share to the program.

Maintaining the solvency of the Medicare program will entail a combination of methods: changes in benefits and cost-sharing, greater contributions from higher income beneficiaries, and consideration of the viability of a defined benefit program after thorough pilot-testing. However, ultimately it may be necessary to provide more funding to the program through payroll taxes and other sources. While raising taxes is not considered to be politically realistic at this time, such measures cannot be ruled out if the Medicare program is going to endure for future generations.

Congress should consider changes to improve Medicare's long-term solvency, but such changes should not lead to more uninsured Americans or violate the basic commitment to provide all beneficiaries, regardless of income, with access to comparable services. Specifically:

1. Congress should not convert Medicare into a defined contribution program.
2. A defined *benefit* voucher program should be tested on a demonstration project basis before a decision is made to implement it on a national basis. The demonstration project should assess the impact of a defined benefit voucher system on adverse selection, continuity of care, fairness, access (especially for lower income beneficiaries) and administrative costs of care.
3. Congress should *not* advance the age of eligibility for Medicare to be consistent with that of Social Security, unless an alternative program is in place to provide coverage to retired individuals who would not have access to employer-paid coverage until they reach the extended age of Medicare eligibility.
4. ACP–ASIM supports requiring that higher income beneficiaries pay higher premiums to remain in conventional Medicare.

If necessary, ACP–ASIM would support mandating a modest increase in the Medicare payroll tax *now* and/or an increase in general revenue contributions to ensure the viability of Medicare for future generations.

CONCLUSION

ACP–ASIM is pleased that the Administration has outlined important steps in reforming the Medicare program. The College stands ready to assist the administration and members of Congress to implement the recommendations identified in our statement that will ensure: outdated Medicare benefits package that excludes lifesaving medications and preventive services be provided; elimination of complex and unnecessary paperwork that diminishes the time physicians can spend with patients; and that inadequate reimbursement for covered services would be improved.

ACP–ASIM REFERENCES

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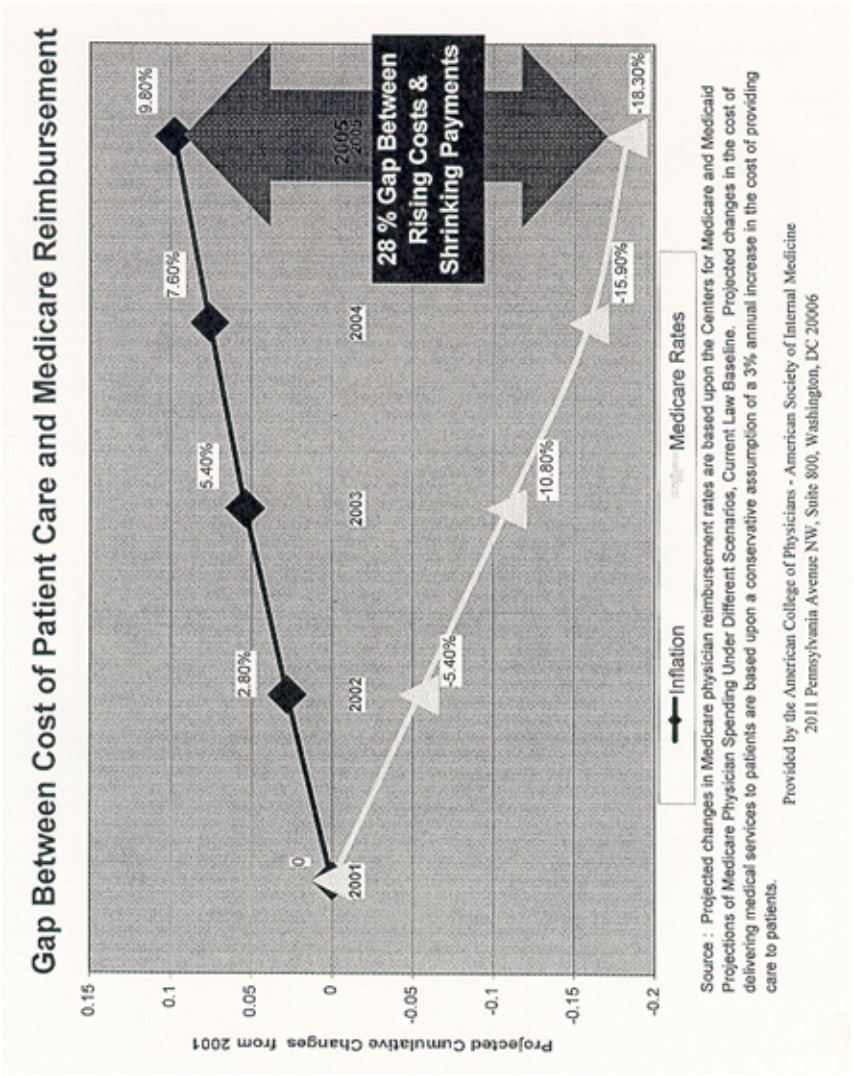
6. Policy memorandum on Adding Preventive Benefits to Medicare, Establishing a Drug Discount Program, and Altering Cost-Sharing Requirements, February 2002.

For more on ACP–ASIM's positions on Medicare reform, please visit our web site *http://www.acponline.org/advocacy*. **To order copies of ACP–ASIM position papers, please contact ACP–ASIM Customer Service at 800–523–1546, extension 2600.**



STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists (CAP) is pleased to submit this statement for the record of the Finance Committee's hearing on the President's proposal for Medicare modernization. The College is a medical specialty society representing more than 16,000 board-certified physicians who practice clinical or anatomic pathology, or both, in community hospitals, independent clinical laboratories, academic, medical centers and federal and state health facilities.

The CAP applauds Sens. James Jeffords, John B. Breaux and Jon Kyl for their leadership in introducing legislation, the *Medicare Physician Payment Fairness Act* (S. 1707), to mitigate the damage caused by this year's precipitous decline in Medicare physician payments and to replace the current annual update formula. The College also is grateful to Majority Leader Thomas A. Daschle, Finance Committee

Chair Max Baucus, ranking member Charles E. Grassley, and other members of the Committee who have supported the need to swiftly address this important issue.

Modernizing Medicare is a worthy and necessary goal that demands a critical evaluation of the current system. As part of that review, Congress must revisit the "sustainable growth rate" (SGR) system used to annually adjust Medicare physician payments and replace it with a formula that accurately reflects the true cost of providing medical services.

Just this year, Medicare physician payments fell 5.4 percent as a result of the update produced by the flawed SGR system. That reduction affects pathologists profoundly and exacerbates existing financial pressures brought on by increasingly complex and costly regulatory requirements and rising liability insurance costs. The January 1 reduction in payments is the fourth payment cut—and the largest—since Medicare instituted its physician fee schedule a decade ago. Since 1991, Medicare physician payment rates have risen an average of only 1.1 percent annually, or 13 percent less than the annual increase in practice costs, as measured by the Medicare Economic Index. Further, the Jan. 1 reduction comes on top of cuts to pathology services made in the transition to resource-based practice expenses, such as an 11.5 percent drop in payment over four years for the diagnosis of breast cancer, prostate cancer and malignant melanoma.

Pathologists and other physicians cannot continue to sustain the financial pressures the Medicare program has placed upon them. Compounding the current problem of falling payment rates are numerous new administrative requirements imposed on Medicare providers in recent years. For example, documentation requirements necessitated by Medicare program integrity initiatives and various provisions of the Health Insurance Portability and Accountability Act of 1996 have created substantial new paperwork burdens in laboratories and physician offices, and more are expected in coming years. These requirements raise the cost and complexity of providing care, but come with no additional compensation. We appreciate this Committee's commitment to reducing regulatory burdens, as well as the efforts of the Centers for Medicare and Medicaid Services. Yet, this relief cannot serve as a substitute for what is really needed: an alternative payment approach that meets the needs of Medicare patients and better reflects the costs of their care. Further adding to the burden on providers are rising professional liability insurance rates and the cost of technological advances critical to maintaining state-of-the-art medical care.

The 2002 payment cut stems from the flawed SGR formula. This system inappropriately reflects downturns in the general economy and that, along with data errors by the Centers for Medicare and Medicaid Services, have short-changed physicians by $15 million since 1998. The Medicare Payment Advisory Commission (MedPAC) warned last year that significant cuts in 2002 "could raise concerns about the adequacy of payments and beneficiary access to care." MedPAC adopted a recommendation that Medicare replace the SGR with a system based on estimated changes in physician practice costs less an adjustment for growth in multifactor productivity (labor, supplies and equipment—not just labor, as is now the case).

MedPAC's concerns regarding access must not be taken lightly. Experiences with Medicare+Choice disenrollment and Medicaid patient access give ample evidence of the need to maintain adequate payment to ensure adequate access. This year's reduction and future cuts that are likely absent immediate changes to the update system will force some physicians to discontinue accepting new Medicare patients, switch from participating to non-participating provider status, reduce administrative staff, retire early or take other actions to limit their Medicare liability. It is unfortunate that those same actions likely will jeopardize Medicare patients' access to care.

The CAP urges Congress to act this year to mitigate the 5.4 percent reduction to the Medicare physician fee schedule, repeal the sustainable growth rate system and replace it with an update formula that accurately reflects increases in practice costs.

The College thanks the Finance Committee for the opportunity to present its views on this important issue and offers its support and continued assistance as Congress seeks to remedy the flawed SGR formula and restore equity to Medicare physician payments.