

**STRENGTHENING AND IMPROVING  
THE MEDICARE PROGRAM**

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**HEARING**  
BEFORE THE  
**COMMITTEE ON FINANCE**  
**UNITED STATES SENATE**  
**ONE HUNDRED EIGHTH CONGRESS**  
FIRST SESSION

—————  
JUNE 6, 2003  
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## **STRENGTHENING AND IMPROVING THE MEDICARE PROGRAM**

**FRIDAY, JUNE 6, 2003**

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

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

Also present: Senators Hatch, Nickles, Snowe, Thomas, Santorum, Frist, Bunning, Baucus, Rockefeller, Daschle, Breaux, Conrad, Jeffords, Bingaman, and Lincoln.

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

The CHAIRMAN. Good morning, everybody. I welcome everybody to this hearing on one of the most major changes in any social program that the Federal Government has had. This would be the first major change in Medicare since 1965 when the program was instituted.

Obviously, at a hearing like this, we are exploring ways to improve Medicare. This is an issue that is very familiar to this committee. In fact, since 1999, the Finance Committee has held 29 hearings on the Medicare subject generally, and 7 of those have dealt specifically with the Medicare prescription drug programs.

So we ask the question, why do we then have yet another hearing? Next week, this committee will do the historic steps that I have described. We will be marking up legislation to create a prescription drug benefit within Medicare.

Last year, the committee process was bypassed. We debated prescription drugs on the floor of the Senate without the due consideration of the Finance Committee, and that was beyond the control of the Chairman of the committee at that time.

But this is a different year. We have an eye towards mark-up next week. In the tradition of this committee's bipartisanship, several members requested today's hearing to further examine various policy questions and options.

Many look to the Federal Employees Health Benefit Program as a model for Medicare. Federal employees all over the country, even in rural States like mine, have a choice of private health plans. Many of these plans are preferred provider organizations, or what we call PPOs. With the quality and innovation that PPOs offer, many believe that the Medicare program could be strengthened

and improved by developing such an option for Medicare beneficiaries.

The health policy experts that we have here today are able to shed some light on what these PPOs are all about, how they work, and how they could be used to deliver better health care for our seniors.

Our first witness will be Mr. Tom Scully, Administrator for the Centers for Medicare and Medicaid Services. He is going to be followed by our second panel, which includes Walton Francis, an author and independent consultant, and Ms. Marilyn Moon from the Urban Institute, who I first met, I guess, in the decades of the 1980's when she attended a hearing in Iowa that I had.

All three of these people have been deeply involved in health policy analysis, research, and administration for many years and we are fortunate that they can join us.

Senator Baucus?

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

Senator BAUCUS. Thank you, Mr. Chairman.

First, I want to thank you for your willingness to work with me, and not only your willingness, but your inclination just to work with Senators to get results and get solutions. This is another example of how you have done that, Mr. Chairman, and I deeply appreciate it.

The CHAIRMAN. I thank you.

Senator BAUCUS. You are welcome.

I would also like to thank other members of the committee who also have worked very hard on Medicare for a good number of years. I see Senator Breaux on my immediate right, who is probably at the forefront of Medicare reform and has been for many, many years.

We are here in significant respect because of his early work in Medicare. In addition, Senators Snowe, Hatch, and Jeffords for their work over the years. They have spent a lot of time helping us get where we are.

Now, some may take issue with the speed of these deliberations. While I do not agree with them in all respects, I will say this. I firmly believe that we should not proceed until we have a cost estimate of the plan from the Congressional Budget Office.

My understanding, Mr. Chairman, is that perhaps Sunday is the date that CBO has said they will give us a final estimate. It is very important to me personally that we get that estimate before we proceed to a mark-up. If we do not have those numbers, Mr. Chairman, we are going to have to have a discussion as to where we proceed from there.

We are at an important point. Sometimes there comes a time when you have to fish or cut bait. We have \$400 billion on the table specifically earmarked for Medicare reform and prescription drug benefits. We have been at this point before. We had a pass-by in the past. Now is the time to act.

Yes, it would be nice to have more funds available for this policy, and yes, a richer benefit would be more desirable. But the question

is, will we let the opportunity to use these funds pass us by again? I do not think so.

This time it is going to be different. This year I believe the stars are much more closely aligned. Chairman Grassley and I have worked together to put a solid framework on the table that I believe will help seniors.

The President is interested in finding a solution here. I think most seniors are interested in finding a solution. There are just more people that want to work together this year, I find, than in past years.

This is not a perfect package; nothing ever is. Sure, there are provisions that I would like to see in the bill and others I might not have included. But I think it is a good bill and a good start toward helping seniors get the prescription drug coverage that they need.

Getting everything you want is not what Congress is about. None of us can pass a bill by ourselves. The bill we pass will be a product of many different opinions, many different points of view. Too often, it feels as though people do not want to even try to work together.

But by not working together, the only people we would be hurting would be the ones we are elected to serve. The framework that Senator Grassley and I have outlined publicly yesterday would establish a voluntary drug benefit under a new Part D of Medicare.

If a senior decides to join a private managed care or preferred provider plan, then the prescription drug benefit would be rolled into that plan. If a senior decides to stay in traditional fee-for-service Medicare, then the senior would receive drug benefits through a stand-alone plan. But the value of, and the subsidy toward, the prescription drug benefit would be equal for seniors who move into private plans or who stay in fee-for-service.

Unlike the President's plan, this proposal does not force seniors, 90 percent of whom are in traditional Medicare, into a private plan that they neither want or need. This is especially important to rural areas like my State of Montana, where most seniors do not have the option of moving into a private plan, because those plans just do not exist.

That leads me to my next point. Under our proposal, Chairman Grassley and I included a strong government fall-back. Seniors must have access to at least two private plans for a prescription drug benefit or the government will provide a fall-back plan. If there is not true competition, then traditional Medicare will provide the fall-back.

We have also focused on making sure that the drug program is accessible and affordable for our low-income seniors. Low-income seniors would pay more than the minimal cost sharing at all levels of spending. We have done much to eliminate what people called a "donut" of high co-payments for low-income seniors.

I have a good feeling about the progress we have made. We are on the right track. The proposal Chairman Grassley and I are working on is still very much dependent on the CBO score which we expect to receive Sunday. I anticipate that changes may need to be made, but we are in a good position.

I would like to thank the Chairman for seizing this opportunity to work together. I would like to extend an invitation to all of my Finance Committee colleagues and ask them to join us to work together to develop this historic Medicare prescription drug bill.

I believe that it is time, time to take advantage of the opportunity that is available to us and pass a good bill, and time, more importantly, to help our seniors. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Our first witness is Tom Scully. Would you proceed? I have already introduced everybody, so would you proceed with your statement? We would like to have it be fairly short so we can have time for questioning. I hope that does not bother you too much. I mean, like 5 minutes. Is that all right?

Mr. SCULLY. As fast as I can, Mr. Chairman.

The CHAIRMAN. All right. Go ahead.

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

Mr. SCULLY. Thank you, Mr. Chairman and Senator Baucus, for inviting me to speak today.

Medicare is a terrific program. No one over the age of 65 is uninsured. It is a community-rated social insurance program and seniors love it, with good reason. Seniors and the disabled depend on it and it has been a very trusted part of the social fabric for many years.

However, it is based on a 1965 Blue Cross model, as you mentioned, and we really firmly believe it is a great step forward to make Medicare look like a 2003 Blue Cross model, and to modernize the Medicare program to make it more responsive for seniors and disabled.

Medicare, which as you mentioned I run, has great provider participation. But by statute, we fix prices. We do not negotiate with providers. We make no distinction for price, volume or quality. Again, while it is a wonderful program that covers everyone, we think it is a very inefficient model.

For example, inpatient prices for hospitals went up almost 10 percent last year; physician spending, Part B of Medicare, went up almost 9 percent last year; home health about 8 percent; durable medical equipment over 20 percent.

A couple of other examples illustrate how our program is quasi-non-functional, such as average wholesale price for drugs. As you all know, we consistently pay about 25 percent too much for the outpatient drugs that we pay for, and we have a 30 percent inflation in Medicare drugs last year.

Additionally, in one of the greater loopholes in the Medicare program last year, we paid \$2.1 billion in hospital outlier payments to the wrong hospitals for the wrong services, and did not even know it. We had done that 4 years in a row. That is 2 percent of total hospital spending.

In our centrally-run system, it went out the door with us understanding it. We do not believe that would happen in a modern insurance system where we understood the dynamics of what was



going on. I think those are just some small examples of why we think the Medicare program needs to be fixed.

The President and the administration started out over a year ago trying to figure out how we could come back and get over the hurdles that had slowed down and prevented a compromise in the bipartisan Medicare Commission that Senator Breaux was so involved in a few years ago.

We sat down and tried to spend a lot of time talking to Senator Breaux, Senator Rockefeller, Bruce Laddock, one of my predecessors, Stu Altman, and many others to figure out how we could come up with a compromise that would move the ball forward.

The two things that seem to hold up the Medicare Commission above all, were raising the retirement age to 67, which we did not do in the President's framework, and the premium support model, which, while we strongly support it, obviously was controversial and some people thought would push the traditional Medicare program into competition with private sector health plans that might drive up premiums.

We also affirmatively decided not to do that. So we really set out to get over this and try to come up with a kind of bipartisan framework for compromise that you and Senator Baucus have moved forward today.

We set out to address this so that, in 15 years—I can tell you that President Bush for sure feels that when he comes back in 15 years, he wants to see the Medicare program be better and improved and provide better services.

I worked with many of you since the beginning of the first Bush administration in 1989 when I worked at OMB, and I can tell you that when I came in to run the program 2 years ago, it is basically the same program it was in 1989. I think we all feel very frustrated with that and we do not want to come back in a decade and a half and find out it has not changed again.

Let me just briefly outline some of the strongly-held views in our framework that we wanted to accomplish. One, was a viable PPO option. We believe that over 70 percent of the people under the age of 65 have chosen that option in the last decade.

We have more than 130 million people in the commercial sector and PPOs. When people are given the options, they tend to choose that one and we think it one that is very viable in Medicare. We think we should have a PPO structure that will promote competition.

We believe that traditional Medicare has to continue to be available as it is for all seniors. The President feels very strongly about that. We believe there need to be reforms in both the traditional Medicare program and the new Medicare programs to provide more efficient and cost-conscious behavior.

The President personally very strongly, I can tell you, believes that low-income seniors need extra protection for prescription drugs. I can assure that in our debates over this in the last 12 months, the number one thing he has consistently said is, make sure we provide prescription drug coverage, especially for the lowest income.

We also believe that this can be done within a \$400 billion scoring. We believe that is the appropriate amount and it is in the

House and Senate Budget Resolutions. We also are very anxious to see what the scores of these various packages work out to be.

I have attached two charts to my testimony that I think show why we feel strongly that the PPO option, while all seniors should get to keep the traditional Medicare option, is a very viable one. When seniors now choose Medicare, the bulk of seniors choose the Medicare plan and the average is a \$7,000 per-senior benefit; they pay \$700, the government pays \$6,300.

On top of that, they generally go out and buy Medigap insurance if they are not on a retiree health care plan. The average of the AARP Medigap plans this year—there are 10 of them—is \$2,200 for an individual. That is a lot of money. That is all out of the seniors' pockets.

On top of that, if you look at the mid-range of what we think the actual value of the House and Senate plans would be and what we know from our own deliberations in the administration, a drug benefit is going to be about a \$1,200 actuarial value in additional insurance for a drug benefit. Conceptually, the senior would pay a third, about \$400, and the government would pay two-thirds, about \$800. These are all kind of very generalized numbers. But when you look at that, the average senior that chooses traditional Medicare gets a community-rated, well-structured Medicare program that covers about 60 percent of their costs.

On top of that, they buy a Medigap plan, which generally is not community-rated, is generally a very poorly structured insurance plan, does not create great value, and on top of that they are going to buy another individual, frequently not community rated drug package. That certainly is a viable option for seniors. It is one that we think we should provide as an option in the traditional Medicare.

But we believe that what most people under 65 get, and what we think many seniors would prefer, is the second chart, which is an integrated benefit where you get your hospital coverage, your physician coverage, your supplemental coverage, your drug coverage in one package through a Blue Cross plan or a CIGNA as a PPO. It may not be for all seniors, but it is what 70 percent of the people who are under the age of 65 choose.

We think that if seniors have that option, they will get a much more efficient insurance package with much better benefits in a much better structure that is a lot easier for people to provide in an efficient model. So, that is why we feel strongly, and we appreciate very much that your bipartisan agreement has PPOs as an essential function of that.

Let me just say in conclusion, Mr. Chairman, based on a quick review of your agreement, which we only looked at in the last 24 hours, we have a lot of questions, I think, as you still do.

But the President sent up a framework to Congress with good reason. We did not send up a 200-page legislation, we sent up a framework. The President feels, you legislate.

We have tried to work in partnership with people on both sides of the aisle to get this done. We have a lot of concerns. As you know, we did have some changes and different ways we provided a drug benefit.

We would like to ensure that people move into what we consider more efficient plans as fast as possible. We think that is better for seniors in the long run. We may have some disagreements on how that is done, but I think the administration feels that your agreement is clearly a step in the right direction.

Again, we have not seen the details in the bills, so we would like to at least reserve the ability to look at scoring and look at other details and move forward.

But, clearly, the President wanted to get something done this year. He has said that repeatedly all winter. He said that when he set up this framework. Our goal is to get this done. It is long overdue.

We have tried to make sure this worked in a bipartisan way all year. We are very happy that the committee has started off in a bipartisan way. We are very interested in working with the committee this year to get this done.

We are sure there will be some differences in the House and some differences in the Senate, but our view is that the real goal here is to get this done before the end of the year. Many of us have worked on this for decades and it has not happened, and we believe that this is the year to do it.

Thank you, Mr. Chairman.

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

The CHAIRMAN. Thank you, Mr. Scully.

We will take five-minute rounds, and they will be in this order: Grassley, Baucus, Bunning, Breaux, Conrad, Bingaman, Kerry, Thomas, Snowe, Santorum, Nickles.

I will just have two very broad questions for you and I will ask them separately. You said that the centerpiece of the administration's Medicare reform plan is more private choices, more competition.

Now, it has been said that the administration really wants to just—I suppose different people have different meanings of the word “privatize”—privatize Medicare. Is it correct to see the administration's proposal as attempting to privatize?

What would be the role of CMS relative to the private plans in the administration's proposal? What protections would consumers have if something along the lines the administration proposed would be enacted? I ask that question, and obviously Senator Baucus and I have deviated to some extent from what the administration has wanted.

Mr. SCULLY. Mr. Chairman, I think the basic goal, as we have noted, is to privatize Medicare. It is basically, the most optimistic assumptions for having people move into private plans, we are probably talking about less than half the people.

So as far as the eye can see, you are going to have more than 50 percent of the people in traditional Medicare. We think we can give them a more efficient option.

The Federal Employees Health Benefit Plan is a government-run program that covers eight million seniors and beneficiaries, and it is done through private insurance companies, but run by the Federal Government. Likewise, Tricare, which is another one of our models, which is the Defense Department's program that also uses

private insurance companies, but is run by the Federal Government.

We think the great benefit of Medicare is that it is a community-rated insurance plan that everybody is in, that is run by the Federal Government, that provides a social insurance benefit at the same cost to everybody. That does not mean that the most efficient way to run it is to have my employees set prices in Baltimore, which is what we do. We believe there are more efficient ways to go. Clearly, the President's plan envisions having any senior and anybody who is even 25 years old now, if they want to stay in traditional Medicare forever, they can.

We also think that people under 65 who move to these hybrid PPO plans that have been very successful, very popular, right now if you are 64 years old and you turn 65 and you are in a Blue Cross of Iowa plan, you have to drop out of Blue Cross of Iowa's plan, enroll in Medicare, and buy a more expensive, less efficient Medigap plan.

We think many people would greatly prefer as an option to stay in the plans they are happy with and probably get better benefits for less cost, but it is purely optional.

The CHAIRMAN. And consumer protection. You did not address that.

Mr. SCULLY. On consumer protection, again, Mr. Chairman, the President's plan was a framework. We spent a lot of time thinking about consumer protections. There would be a separate—under both your proposal and the President's—agency broken out of my agency under HHS, Center for Beneficiary Choices, I believe is the label you had.

We are very supportive of that. We are very concerned about making sure that we have a separate agency that officially oversees these new programs, and we would be very supportive of any consumer protections that we could put in.

The CHAIRMAN. All right. Then my next question comes from something you hear me and Senator Baucus talk about quite a bit, representing rural States: the President's plan would rely on private preferred provider organizations, a type of health plan that can provide more integrated care and in which many Americans are currently enrolled.

But what assurances can you provide us that these PPO plans will be willing to serve Medicare beneficiaries in rural communities? I use as a basis for my question working so hard to increase reimbursement for Medicare+Choice for rural America, and we had less than \$3,000 reimbursement in 1997, and we have that up to about \$490 per month as a national floor.

We still only have one county in my State that is served by Medicare+Choice, and that county was being served even before we raised the floor. So, we need to be sure that these organizations serve rural America.

Mr. SCULLY. Mr. Chairman, I think they already do. One of the reasons we came up with the Medicare+Choice plan is that HMOs generally do not exist out of urban areas, or certainly larger populations.

Despite our best efforts to have Medicare+Choice plans go to rural areas, that has not happened. PPOs generally exist in rural

areas, and 92 percent of the doctors in the United States are involved in a PPO network.

Last night, I called Senator Baucus' and my mutual friend, Dan Muniack—I did not get ahold of him—out in Jordan, Montana, where we spent a lot of time working last year where there is one physician's assistant and one hospital, and nobody within 100 miles in any direction. He is a member of Montana Blue Cross and is enrolled in their system.

I was in North Dakota a couple of weeks ago with Congressman Pomeroy, and virtually everybody in the State of North Dakota under the age of 65 is in the Blue Cross of North Dakota PPO.

So I think the fact is, when you look around the country, the difference between HMOs and PPOs is that PPOs effectively are fee-for-service that are broadly, broadly available in rural areas.

The CHAIRMAN. Thank you.

Senator Baucus?

Senator BAUCUS. Yes. Tom, as you very well know, having worked at OMB and now at CMS, and are very involved in actuary's estimates that say how efficient these PPOs will be or not be, that is, will they be more costly in delivering, let us say, service or not?

Actuaries at CMS have found them to be pretty cost-efficient, whereas CBO, which is the organization that we have got to go by here, does not think they are going to be very efficient and actually are going to cost more.

What is the basis of that? Clearly, there are differences of opinion, but in some sense that is irrelevant because we go by CBO. That is the organization that decides what these costs are or are not. What do you think explains the difference between the two estimates?

Mr. SCULLY. Unlike in some tax scoring, generally CBO, and CMS, and the former HCFA, actually, generally agree within half of a percent. I think traditionally, over many years, the CMS actuaries have been perceived to be extremely nonpartisan and objective. So, I do not think there is any political difference. I think it is purely a substantive difference in judgment.

I have great respect for CBO. The top two health people at CBO used to work with me at OMB. They believe that, by their information, because Medicare can set prices, and obviously we can set prices wherever we can set them, that Medicare pays 10 to 12 percent less per procedure on average, in some cases, than private health plans. Our actuaries do not necessarily agree with that.

The other thing is, our actuaries really believe that there is a lot more utilization control and management. Although it is very loosely managed, the PPOs do manage utilization.

I think CBO will probably—and they will have to give you their score—find that the PPOs cost more than fee-for-service. Our actuaries believe that the PPOs cost—it is not a huge savings—about 1 percent less than Medicare fee-for-service.

Senator BAUCUS. What accounts for the difference?

Mr. SCULLY. The difference is that our actuaries have looked extensively—obviously I am biased towards my actuaries—at Tricare and the FEHBP model. Also, for the last year we have had 34 PPO demonstration programs going around the country, and we have ac-

tually had people coming in and telling us what they would pay for the services.

Our experience has been that the better PPOs are coming in at below fee-for-service just a little bit. This is not going to make up for the cost of a new drug benefit, but we do believe that they are going to provide better benefits.

To simplify it, and just to personalize it, my mother, for instance, has been in the hospital for seven weeks on Medicare. I think she probably has a \$400,000 hospital bill, is my guess. She has had four MRIs and two CAT scans in three different hospitals, and there is no utilization management. It is a wonderful program, but if a doctor certifies it, Medicare does the test.

HMOs probably push people too much in utilization, but PPOs, at least somebody at Blue Cross of North Dakota would be calling up saying, how many tests do we need, what is the best setting, how long she should be in a certain setting.

Medicare has no utilization controls at all. It is basically a fee-for-service/check-the-box system. I think most Blue Cross plans and most private insurers, obviously they cost more to administer, which is one of the other differences. But you actually have some administrative oversight and they actually try to talk to physicians, hospitals, and doctors and help them put people in the right place.

Senator BAUCUS. Right. But one of the provisions in this bill, at the behest from the Senator from Arkansas, is more incentives for disease management and coordinated care in fee-for-service.

I think it is widely recognized, as you have stated, that that is a deficiency. That is a problem. But to say it is a problem, is not to say we cannot find a solution. We are attempting to try to find the beginnings of a solution to that problem.

Given CBO's concern about that private plans are actually going to cost more, not less, do you think we should maybe place a limit on payments to private plans so we do not simply just allow plans to have an unlimited tap on government spending?

Mr. SCULLY. Well, certainly we have no desire to pay private plans more than Medicare. I mean, it is a philosophical difference and a technical scoring difference. Obviously, we believe in competition between health plans and we have limited it to three per region, which we believe will drive down prices and be more efficient.

So, philosophically we do not like the idea of tying prices to a fixed cost because we think it is going to save money, but if that is what it takes with CBO to have them get the bill through at the right amount, because we do not agree with them, I think we are willing to talk about that and work with you on that and we understand it. But I think we actually believe we are going to save money on the PPOs; they do not. I understand you have to live with their scoring.

Senator BAUCUS. Yes. They are the ones we go by. Thanks. Thank you very much.

Mr. SCULLY. Thank you.

The CHAIRMAN. Next on the list would be Senator Bunning.

Senator BUNNING. Thank you, Mr. Chairman.

Tom, I would like for you to clear up for the people in this room and for anybody that happens to be watching exactly who we are

talking about and the different ratings and eligibilities of the people in certain little boxes of seniors.

Dual eligibles. Who are dual eligibles?

Mr. SCULLY. Truly dual eligibles are people generally between about 74 and 100 percent of the poverty level that qualify for Medicare.

Senator BUNNING. The poverty level being what?

Mr. SCULLY. I should know that. But I think——

Senator BUNNING. It is \$6,555 for an individual, \$8,848 for a couple.

Mr. SCULLY. Thank you. Yes. And the States pick up the cost. Medicare has significant co-payments and deductibles. Medigap covers those costs as well, \$2,200 per individual, per year, on average. States pick up that cost for low-income people who cannot afford it and they pay the deductibles and co-payments for Medicare.

Senator BUNNING. They would be in this benefit we are talking about?

Mr. SCULLY. This drug benefit?

Senator BUNNING. This drug benefit that we are discussing adding to Medicare.

Mr. SCULLY. Significant help for low-income seniors. Very significant.

Senator BUNNING. All right. I just want to clarify because I do not think anybody knows who we are talking about here. Qualified medical beneficiaries. Who are they?

Mr. SCULLY. Those are our slightly higher income category, and they split up in a whole bunch of subcategories between 100 and 135 percent of poverty for a whole bunch of different categories of different levels of subsidy for Medicaid.

Senator BUNNING. That number, exactly, is \$8,980 for an individual and \$12,120 for a couple. So, we are loading this, or trying to load, to make sure that these lower income seniors get a better benefit than they presently have under this program.

Mr. SCULLY. Low-income seniors will by far be the biggest beneficiary of any of these bills.

Senator BUNNING. Specific low-income beneficiaries, or SLIMBs, as they are called. There are approximately 500,000 to 1 million of those. Who are they?

Mr. SCULLY. Once again, a slightly higher income category of low-income people who get slightly lesser subsidies in the States for Medicare.

Senator BUNNING. That is a \$10,760 individual and a \$14,500 couple.

Mr. SCULLY. Yes.

Senator BUNNING. And qualified QI-1's, or qualified individuals, are another 500 to 1 million people. Who are they?

Mr. SCULLY. All right. Once again, you have the slightly higher income category. As you go up, they get even lesser of a subsidy from the States.

Senator BUNNING. So the people that I talk about are, if we go from qualified medical beneficiary to the QI-1's, we are talking about less than 3 million people?

Mr. SCULLY. That is probably right.

Senator BUNNING. Three million seniors. And this benefit would be more advantageous for them than the current Medicare Part B and/or a supplemental, and/or Medigap, or whatever else they have?

Mr. SCULLY. Many of them have no drug coverage now. It depends on the State.

Senator BUNNING. Well, I know that. But they would under our new program that we are discussing.

Mr. SCULLY. I have not seen the Senate's, but I am assuming, from talking to staff, that the Senators' proposal is similar to what we did. They would all get a very extensive drug benefit that I would assume would be between \$2,500 and \$3,500 per person, per year.

Senator BUNNING. What about people that are under Medicaid? What are we talking about doing for them, or are we talking about doing anything for seniors?

Mr. SCULLY. Most of the seniors in Medicaid, depending on the State, have waivers, like Illinois, up to 200 percent of poverty. But most States, the Medicaid coverage is the dual eligibles, the SLIMBs, and the QI-1's you discussed.

Senator BUNNING. Well, that is what I mean. Are we going to do something in the new benefit or are we going to keep them in Medicaid?

Mr. SCULLY. The new benefit essentially covers all of them through Medicare. Some States, it depends on how it is structured. I am not certain how the Chairman and Senator Baucus have structured theirs, but under the President's proposal they would all be covered under the new drug benefit, with a very significant drug package.

They could potentially stay in some of the existing programs, like PACE in Pennsylvania, and others, depending on how it is structured. But they will all get a very, very significantly increased subsidy for drugs.

Senator BUNNING. The reason I brought that up, is that there are a lot of people that are senior citizens that do not understand that this benefit is going to take care of the extremely needy in our country, the extremely needy seniors, that they are prioritized in this benefit.

We are also going to have the benefit for those who I do not think we should, the Warren Buffetts of the world, and everybody, almost, sitting around this table here at the committee level who does not need a prescription drug benefit on their Medicare. They all can afford to buy one.

Mr. Chairman, my time is up, but I had a lot more questions. But, thank you.

The CHAIRMAN. Thank you.

Our next person is Mr. Breaux, but our practice has always been, if the Democratic and Republican leaders are here and they are under time constraints—

Senator BREAUX. I would be happy to yield. It is no problem.

The CHAIRMAN. I would call on, in order of arrival, Senator Frist, then Senator Daschle, if you want to have us take you out of order.

Senator FRIST. Thank you, Mr. Chairman. I will be very brief.



Let me just say thank you, both of you, the Chairman and Ranking Member, for today's hearing. We have set aside 2 weeks on the floor and really backed that out starting a couple of months ago.

Although people recognize it as an ambitious timeline, it is built upon a lot of the discussions and debate this committee has had with the 28, 29 hearings we have had in the past. So, I am very comfortable with the timeline that is on the table and we will adhere to that timeline.

I want to thank both you and the committee for making that possible, putting this hearing together so that we can continue to engage in the discussion of the issues that are so important to this program, to the seniors, and to the future of the practice of delivering quality health care and health care security for our seniors. So, I appreciate that.

Let me just jump straight in with one question that has to do with the paperwork regulatory burden that faces the caregiver, the physician, the nurse, in hospitals and in the outpatient setting today.

It is well-known that Medicare today, because of the evolution of the program without major modernization, has an increased regulatory burden that gets translated down to the patient care level.

We all recognize that we need better value for the investment of whatever dollars that are ultimately put into the Medicare program today and into the future as we go through this major expansion of benefits and this new investment.

A recent Price Waterhouse Coopers report found that caregivers spend, on average, at least 30 minutes on paperwork for every hour of patient care provided for a typical Medicare patient in certain settings. Thirty minutes of paperwork for an hour of patient care.

Part of this is due to Congressional mandates that we come through as we attempt—because that is our handle in micromanaging and telling you or Medicare what to do in terms of the regulatory burden.

You, as the administrator, have tried to correct some of this. Yet we had the Office of Personnel Management, at least, tell us that they have a great deal more flexibility in administering the program that is not a model for what we are doing, but one that we need to draw upon with 40 years of experience with the Federal Employees Health Benefit program. You understand it, and are in the middle of administering Medicare in terms of this regulatory burden.

What advantages will we see in this new, enhanced Medicare Advantage option? The purpose of it, I understand, is to have an up-to-date delivery system that includes preventive care, catastrophic care, chronic disease management, all the sorts of things that are so lacking in traditional Medicare today.

Not that we cannot improve traditional Medicare as well, but in terms of the regulatory burden, increased flexibility so that we can adapt with the times as we figure out even a better way to deliver care, it is not locked in stone like traditional Medicare has been.

Mr. SCULLY. Well, if I can use an example. I was in North Dakota a couple of weeks ago with Congressman Pomeroy and Congressman Moran who chaired the rural caucus in the House. I explained to them, because there is a lot of fear in rural areas of how

this is going to change things, that if you are 64, you are, in North Dakota, almost always a member of Blue Cross of North Dakota, and you negotiate, as a hospital or doctor, with the local insurance company that you know and they have a very good relationship with, and things work out pretty well.

If you are 66, Blue Cross of North Dakota, who is my contractor, still pays you, but they pay you off of a rate schedule that is fixed in Baltimore by my staff, with lots of rules, and you basically the same people who are paying out of the Federal pot if you are 66 as out of the local Blue Cross if you are 64.

I think the providers in North Dakota, and every other State in the country, in Tennessee, would find that—doctors and hospitals never love insurance companies, but they generally have a much more rational local relationship in working out care and payment than they do when they get national prices fixed in Baltimore and Washington.

I guess one of my frustrations is, and I think it is all around the country, is that we pay every doctor the exact same amount, whether they are the best doctor in Nashville or the worst, and every hospital the same whether they are the best one in Pittsburgh or the worst. I think local flexibility with local ability to adapt to local practice patterns and local care is the best thing that will come out of this.

Senator FRIST. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Frist, Senator Baucus and I are going to try to meet the deadlines that you have set to have this ready for the floor. But Senator Baucus has made a very important point several times, and I want to emphasize along with him, that a lot of this depends upon CBO getting us scores.

Now, they have promised to get us scores by Sunday night, and we will need a little time to adjust according to what they score various things. But we need to keep that in the back of our mind.

Senator FRIST. Mr. Chairman, let me just add, it is absolutely critical. The reason for setting aside, months ago, when we were going to do this, is to allow us, CMS, as well as CBO, to prepare and to be available during that period of time.

So I will personally, and I think the message from this committee is, tell CBO we need them to focus, and focus almost exclusively, hopefully, on this. Because even in the amendment process as it goes forward, it is going to be very important that we get feedback on an online, ongoing basis as we go through to accomplish what is ambitious, but is a goal that we will meet. We will complete this before the July recess.

The CHAIRMAN. Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman. I would share your concern about CBO, not only for the bill itself, but the opportunity to offer amendments. Obviously, at times if a CBO score is not available and an amendment is not provided the opportunity to be offered, and I would hope that we could offer amendments even if CBO has not scored it just because of the time constraints under which we are working.

Let me begin by complimenting our Chair and Ranking Member on the rural provisions in this bill. I think that it is one of the best

sets of rural provisions we have seen. Rural providers are addressed here in ways that we have wanted for some time, and I am grateful to both of you for your advocacy of the attention to rural needs.

I want to welcome Tom Scully. We appreciate his counsel on many of these issues as well.

I want to focus, in the time that I have, on just two issues. One has to do with the model, the other has to do with the design, of the package. I would like to ask a question in regard to both because I have concerns about both.

Insurance companies generally have always been reluctant to get into this, in part, because insuring seniors' prescription drugs is a little bit like insuring a haircut: you know it is inevitable, and because of that you cannot make the actuarial tables work well.

So what we are, in essence, doing, is we are paying the insurance companies to provide the coverage, to go into areas of the country that they would not normally go in, and maybe to the whole country, getting into a business that they normally would not do because, actuarially, it is not sound. So we are incenting them, we are paying them.

The question I have, I guess, is is that the best use of those resources, to pay the companies rather than to provide the benefits? Because it is a trade-off. It is either more benefits or more incentives to the companies to provide the benefits. But that money is going to go in one of the two pots.

I guess it is for that reason fundamentally, as we have considered the models, that we have said, why not put the money in the benefit side rather than in the incentive side for the private sector to do something they otherwise would not do, especially if you are an advocate of the free enterprise system? So, I would love your comment on that, if I could.

But the second one has to do with the concern for certainty. When I go home and talk to my mother, talk to seniors in South Dakota, the one thing they all tell me, is that they do not want something confusing.

I would not want to admit publicly my mother is a certain age, so I do not want anyone to make this connection here. But if you are in your 80's, let us say hypothetically, I think what you desire is to be able to make decisions, not with the advantage of a lot of professional help like we get with FEHB or that we are able to do as professionals, but they want the certainty, they want the simplicity.

I have four concerns in regard to the complexity of this system that I hope we could address quickly. Not each one, necessarily, but to address this issue.

The first, is the volatility of the system. The volatility is what concerns me the most. Under the bill, we are going to require that two PPOs, two managed care organizations, come into an area, let us say South Dakota, and we give them a time frame within which to do that.

If they do not, then we say, well, Medicare has to kick in. But even if they do, even if we find two, they only have to stay there a year and then they can leave. If they leave, then Medicare kicks in for a year and it can leave. So I see a scenario where the PPOs

come in, they leave. They say they cannot do it, even with the incentives. Medicare comes in, then somebody else says, no, I am going to try it.

With each new organization in and out of the system, you are going to have a senior out there saying, I cannot keep all this straight. First it is this, then it is that.

I think, in the process, there is going to be a tremendous amount of anxiety and concern about the benefits, about the premiums, about the coverage, about the delivery model, about all of this at the very time when seniors are feeling extremely vulnerable.

That goes to the second and third concerns, that is, a lack of standard premium. If you are in South Dakota, as I understand it, there could be a different premium than if you are in New York.

There is going to be a different benefit package. So that lack of certainty with regard to premiums and benefits, too, are very serious concerns. The final concern, in the time I have, is this one. It is the coverage gap.

You can put it in terms of dollars or days, but it is the same concept either way. Because of the deductible, you have no coverage initially in any new calendar year. Then the coverage kicks in after you have paid the deductible and you have coverage for a while.

But then because of the threshold—as I understand it in the bill it is \$3,450—it kicks out. You are still paying the premiums every month regardless of whether you have the benefits, but then the benefits kick in later on when you reach \$5,300.

In this case, it would be, assuming you have a \$400 per-month drug expense, it would kick in in roughly the end of September. So you pay premiums the whole year, you get benefits for a block of time, you start with no benefits, and then you get benefits at the end of the year.

Again, it goes to this lack of certainty, the volatility of the issue that I think is a serious concern that I wish somehow our committee and this Senate could address before we send this bill out to be implemented by you, Tom.

So could you, in the short time we have left—and I realize I have taken most of my time and I do not want to abuse it—share some thoughts about those concerns.

Mr. SCULLY. I hope I will get to all of them, Mr. Leader. But let me say, first, just to start with the standard premium—and again, I do not know how Chairman Grassley and Senator Baucus designed theirs—the President's proposal had a standard premium, so the premiums for the PPO would be identical across the country.

Now, the cost to the government might vary, just as they do in Medicare right now and just as they do in HMOs right now. But at least in our design, the premium was flat across the country and it was slightly below the Part B premium. So, I understand that concern. We were very concerned about that and spent a lot of time on it.

Second, we understand seniors are nervous. That is one of the reasons that we went to great lengths in our plan—even though philosophically we agree with a lot of things in the Medicare Commission—to remove any uncertainty about changing the existing Medicare program.

In the President's proposal, I believe in the committee's outline, traditional Medicare never changes. If you like traditional Medicare, it stays exactly as it is. The premiums are built on the existing population and nothing changes.

So anybody that wants to stay in traditional Medicare as it is can stay in it indefinitely. In fact, at least under our proposal, and I believe under the committee's, everyone in the country gets more. So, even under our proposal every senior would get exactly what they have now, plus a catastrophic drug benefit with no additional cost.

So to the second point. I do not understand the details of your chart, but would be happy to get into it further. But I think one of our frustrations is, I started working in 1989 to try to save catastrophic from being repealed, as many other people in the Senate did. We have been flailing away, trying to get a drug benefit passed for 15 years. I know that every single senior will do better and get more drug coverage under these plans.

Our frustration is, nothing has happened in 15 years. If this plan passes, it may not be perfect. We probably will tinker with it for many more years. But every single senior will be doing better than they are today. There may be some gaps in coverage, but \$400 billion is a lot to spend. We think is the right way to start. I am confident that everyone will do better.

Let me just quickly mention a couple of other things on the PPOs. I understand the great concern, and we also looked at the package with HMOs. The HMO structure has been flawed. I will not get into the details on that. There are many places where HMOs have not shown up and have not worked.

PPOs are much more flexible and they exist every place in the country. We have a lot of experience with them in Tricare, which is a Defense Department program, and the Federal Employees Health Benefit Program, where plans have shown up and have stayed.

I have personally talked to the chairmen of the top 10 insurance companies of the United States. They are all nervous about the experience with HMOs. But under this structure, I have had great assurance, as has the President and Secretary Thompson, that they will participate, as they have in the Defense Department programs and as they have in the Federal Employees Health Benefit Programs, and we believe it is going to work.

But the key thing is, anybody that likes what they have can keep it and they will get more as well. I have no doubt that there is some accuracy in the fact that there are some gaps in our plan and in the Finance Committee's plan, but I think everybody will be better off there today.

The CHAIRMAN. I thank Senator Daschle for highlighting the rural parts of this bill, the provider parts of this bill that he mentioned that Senator Baucus and I have been working on for a long time. I would take this opportunity to explain that I think that we do not have a realization of the importance of this for quality health care delivery in rural America on the part of the House of Representatives.

I would hope that we would have a united, bipartisan front in the Senate, that this is a very important part of this legislation and

no bill is going to go to the President until we get this rural equity issue taken care of.

I thank you very much. I know you are very interested and probably know more about the issue than I do, and have been very concerned about it. But, because of your leadership position, that is the reason I am pleading with you, not because you are not concerned. Thank you.

Senator Breaux?

Senator BREAUX. Thank you very much, Mr. Chairman. Let me be one of many to congratulate you and Senator Baucus for the great effort that you all have been able to put together to ultimately end the long debate that we have had on this subject of somehow allowing the perfect to be the enemy of the good.

Where some have argued that the government should do everything and that the private sector should not do anything with regard to Medicare, others have taken the position that the government should not do anything and the private sector should do everything.

What we have before the committee and the testimony today is on a package that combines the best of what government can do with the best of what the private sector can do.

As Tom Scully has said, this is a government-run program, whether you stay in traditional Medicare or whether you go into the new Medicare Advantage. Just like our health insurance for every one of us in the Senate, it is government-run program that merely utilizes the private sector to deliver the benefits.

And whether you are a Federal employee in New York City or whether you are a Federal employee in the most rural county in the most rural State of America, you get quality health care because we have combined the best of what both segments can do.

On the point that CBO has said that, well, the private sector actually pays more for health delivery services than the Medicare program, I met with CBO. It is interesting.

They assume in their assumptions that the Federal Government and Congress is never going to increase, in the next 10 years, the reimbursement rates for doctors and hospitals. I will bet anybody who believes that lunch in the city and country of their choice.

We will probably do it this month, we will do it next year, we will do it every year. In election years we do it, and we cut in off-election years. So they assume that, well, the private sector pays more.

They cannot—and I am not faulting them—assume that Congress is going to do this in the future. Everybody knows we are. That is one of the reasons the numbers come back differently. The arguments have principally been, well, this cannot work in rural areas. I think you have talked about how rural areas will be very well protected.

The second argument is, well, it is a different population. Medicare recipients are older than Federal employees. The truth is, the average Federal employee under our system is about 47 years of age. When you include the retirees, it goes up to 61. So there is not a huge difference in the age. Obviously, Medicare recipients are older. But if you look at the retirees in the Federal program that

are served, there is a great deal of similarity. So I think that if you look at those questions, I mean, I think there is a clear answer.

The third argument, is that somehow you are going to force seniors into HMOs to get prescription drugs. I think that argument has been taken away because, if you stay in traditional Medicare, you are going to have the same health care drug benefits as if you go into Medicare Advantage.

I was one who argued you ought to have a better plan if you go to Medicare Advantage, but that decision has been made. You will get identical plans if you are in the traditional Medicare for prescription drugs as if you go into Medicare Advantage.

The final argument that I think is made, and I understand the argument, is the question that you have a gap. You have a gap in the plan that, after a senior reaches approximately \$3,450 in drug costs, that we are not going to cover them until they get up to \$5,300 in drug costs.

Well, the average senior in this country spends about \$2,300 on drugs a year, so the average senior does not even come very close to reaching the gap where the coverage does not exist. We will find out from CBO how many people actually fall in that gap.

My estimates say it is only about 7 to 8 percent of the seniors, because many of them do not reach that number. Others have Medigap coverage, others have coverage from their former employers that takes care of that. So, there is a very small number, I would argue, that happen to fall within the gap.

CBO will give us a number; others will say more. But we will have a number from CBO before we go to a mark-up in this committee. So I think the fact is, no low-income senior ever has the gap. If you are under 150 percent of poverty, we will pay for the drugs throughout the gap. There will be no gap for low-income people.

Now, if we have a trillion dollars, there would be no gap, but we do not. If we did not do catastrophic protection for seniors, we could use the money and eliminate the gap.

But we happen to think that catastrophic protection for Medicare recipients, which they do not get today, is extremely important. So I thank you. I think you have touched on the issues that are important. This is a healthy debate.

Last year, we did not have a walk-through. I am not blaming anyone. The situation was such that we did not have a walk-through in this committee. We did not have a hearing in this committee, and we went to the floor with a bill.

This time, we have had innumerable meetings, bipartisan meetings, private meetings with Republicans and private meetings with Democrats. We have had a walk-through with the staff, we had a walk-through with members, and we have a hearing today. The mark-up is not until next week.

So, I think we have gone through a procedural process of which we all can be proud, and I think it is going to produce a product that ultimately we can also be proud of. Thank you.

The CHAIRMAN. The next person is Senator Conrad.

Senator CONRAD. I thank the Chairman, and thank the Ranking Member as well.

It is always good to have you, Tom, here. Let me go to something you said on May 6. In the New York Times, you are quoted as saying, "Stand-alone drug coverage does not exist in nature and would probably not work in practice."

As you know, the proposal we are discussing here today is precisely that. I am interested to know, what has changed since May 6 to make you believe that somehow it now works?

Mr. SCULLY. I am glad it was in the New York Times. [Laughter.] Sorry.

Senator CONRAD. Did you not say it?

Mr. SCULLY. No, I did say that. I am sure I said that.

There has been a debate on this for years. The fundamental issue is, I think you can make it work—and I think the Minority Leader alluded to this—in the way the bill is structured, if it does not work, we would keep coming up with risk quarters until people came into the stand-alone drug benefit.

The President's package does not have a stand-alone drug benefit, for a variety of reasons. That is one of them. As you know, we still feel strongly about a differential drug benefit. We think it is, policy-wise, the right way to go. It is one of our major concerns about this bill. We do think you can make a stand-alone drug benefit work.

But one of the primary reasons we like PPOs, it is hard to come up with—and I just came up with an estimate in the mid-range. If you have a \$1,200 drug-only benefit that is voluntary, you are going to get sicker people drawn into it and it is going to be harder to insure.

But if you take a \$1,200 drug benefit and put it on top of the \$7,000 Medicare package and you have an \$8,200 benefit that includes hospitals, doctors, home health, drugs, in one community-rated package, it is a much more insurance event and it is much easier to insure people for drugs and much easier to come up with an insurance plan that works.

One of the primary reasons we like the PPO model, is that the same model I have as a Blue Cross beneficiaries, on the bottom of my card, it says, "Advance PCS." Two hundred million Americans, on the bottom of their cards, it has "Advance PCS for express scripts." Insurance companies can, in fact, deliver a drug benefit efficiently, and do for over 200 million people through the PPO model.

Senator CONRAD. Let me just say, that is your plan. That is not the plan that is here. I have heard discussion from some that this is a good process. This is not a good process. I mean, I am on this committee, I am the Ranking Member of the Budget Committee. I have not seen any serious description of this plan yet.

I do not have legislative language, I have got no scoring of this plan. I do not know whether this plan has any guarantees that if there are not drug-only plans offered, that there really is a guarantee that a PBM would come in to provide that coverage.

We were told in a briefing, well, that is the intent. But if they are only guaranteed 1 year, why would you set up all the systems to provide coverage when you may be kicked out the next year when drug-only plans come into the market?



I would say to my colleagues, I have great respect for the need to, as the Leader says, get this done this year. But I believe we are rushing in a way that people really do not know what they are doing at this point. This is the only hearing we are going to have.

I heard Mr. Scully say he did not know how the premium was designed in this plan. Well, he is not the only one. I do not know how it is designed. In fact, it is advertised to be a \$35 premium. I find nothing that assures that it is \$35. It could be \$50, as long as there are two drug-only plans that are offering it in a State. That would lock out and prevent somebody from going somewhere else.

Mr. Scully, the Administrator, who I have high regard for, testified dual eligibles are here. Dual eligibles are not in this plan. How can a mistake like that be made? I would submit to you, I do not think you got anything until last night or yesterday. Can you tell me on what basis you are testifying today? What do you have? Do you have legislative language before you on this plan?

Mr. SCULLY. Senator, I have a two-page summary. I have, in the last 24 hours, had pretty extensive discussions with staff about what is in it.

Senator CONRAD. Well, that is the problem, to me, what is happening here. We have got a two-page summary on something that is the most profound change in one of the biggest programs of the Federal Government that has been made in 40 years.

There is no question, changes need to be made. But we are here with one hearing, with a two-page summary and the most basic kind of questions, to me, not being able to be answered.

I just want to say, since last night, since we first got any kind of significant description of what this is, we have tried to do a couple of examples. Beneficiary 1: \$500 of annual drug spending. Twenty-five percent of the people are in that category. They are actually spending, under this plan, \$300 more than they get.

Beneficiary 2: \$1,000. Thirty-five percent are in this category. They are spending more than they get. As you go up, Beneficiary 3, \$2,000, 52 percent of the people in this category, they get 22 percent assistance. On it goes.

My time has expired. I would just say, number one, I think there are real questions how attractive this is, and number two, what the details really are. I think if most of us were given a quiz, we could not answer. I think it is because, frankly, we have not had time to give sufficiently serious consideration to what is an enormously important set of decisions.

Finally, we are going to build a system using drug-only plans when the people that offer those plans say they have no interest in doing it, strikes me as a risky approach.

Mr. SCULLY. I do not want to leave the impression—I hope we are still old friends after this. I have spent thousands of hours over 15 years, but thousands of hours in the last year, meeting with many, many people. I think we spent an hour and a half talking about this a couple of weeks ago in your office. I spent a couple of hours in Senator Rockefeller's office, also an old friend.

The details may not be spelled out in this document, but the options we have known for years. I know you do not like a lot of the

President's proposals, but I have made an effort to try to explain them all to you.

I think the committee's draft, from what I have seen, while we have a significant disagreement about the level of differential drug subsidies and the PPO structure, it is fairly consistent.

I really, with all due respect, think that most people do understand the issues. At least, the administration feels like we have had very thorough access to the staff on both sides and are comfortable that we substantively know where we are going.

The CHAIRMAN. Senator Bingaman?

Senator BINGAMAN. Thank you very much.

Thank you, Tom, for being here. Do you have this table called "The Impact of Potential Prescription Drug Bill on Beneficiary Spending" that the Urban Institute did that Marilyn is going to talk about? Could someone hand that down to him, please?

Let me explain why I am going to ask you a couple of questions about this chart.

Senator BAUCUS. Can we get a copy of that chart so that we all have it?

Senator BINGAMAN. Well, it was on my desk here when I walked in.

Senator BAUCUS. All right.

Senator BINGAMAN. It was in a pile of materials that was here. I assume it was on yours, too.

Senator BAUCUS. Yes, this is it. I found it. Thank you. Thank you. "Table 1," it says on top?

Senator BINGAMAN. "Table 1." Right.

Senator BAUCUS. Thank you.

Senator BINGAMAN. I have heard the President speak. In fact, I think he gave a speech in my State a couple of weeks ago where he talked about how, in his view, he wanted to see everyone have a prescription drug benefit like the one members of Congress have. There is no reason why they should be denied the same kind of prescription drug benefit.

If this chart is right, we are misrepresenting to the American people, and he is misrepresenting, what we are talking about doing. As I understand what we in Congress have, through the FEHBP, what all Federal employees have, we essentially pay 25 to 28 percent of the cost of drugs. That is the normal range.

This chart would lead me to believe that, even if we enact this plan, we are going to have seniors pay a much, much higher percentage of their drug cost than any of us are paying, or that any Federal employee is paying.

As I read this chart, if you are at 175 percent of poverty, if you spend \$1,000 on drugs in a year, you are going to be paying, the beneficiary share of that, \$1,058. I am not exactly sure how that works out, that you are paying more than, in fact, the \$1,000, but I am just alarmed at the figures.

If you are spending \$4,000 on prescription drugs, you are paying \$2,800 of that \$4,000 out of pocket, so the government is picking up, what, 30 percent. If it goes up to \$6,000, essentially the government is picking up \$1,800 of it, so 30 percent.

So instead of the individual patient having to pick up 25 to 28 percent, we are saying the government is going to pick up 30 percent and the patient is going to have to pick up the rest.

Am I misreading this situation? This is all new to me, as to exactly how generous this plan is. But I am very much concerned that we are going to have a lot of seniors in this country feeling that they have had this plan misrepresented to them and that we are essentially promising to provide a drug benefit comparable to what Federal employees get, when the truth is we are not even going to come near to that.

Do you have a thought on this?

Mr. SCULLY. Well, I do not know the details of what is in the Senate package, and we did not put out, intentionally, all the details of the President's framework. But I know, conceptually, how the money would work.

It is probably correct to say it is not for everybody equal to a Senator's or my drug package. Generally, if you are low-income, below 140 percent of poverty, I would say that poor people are going to get a much better package than Federal employees and have much higher subsidy levels and much more thorough coverage, at least under what we had designed.

As you go further up in the income stream, you get less. Generally, I can assure you that every single senior will get more than they get today. The general subsidy mix to what the Federal Government has in most of these plans, and I believe the Senate is designed similarly, roughly, the Federal Government picks up 66 percent, or roughly two-thirds, of what the new insurance costs are and the beneficiary pays one-third.

So, as you go further up in the income stream they do, in fact, get less, but I believe that low-income seniors will get significantly more than Federal employees.

As you get further up in the income stream, they will definitely not do as well. So, I clearly do not think we should mislead people who are further up in the income stream.

Senator BINGAMAN. Let me ask one other question. Senator Daschle asked you about this problem of a one-year requirement for these companies that want to participate. I noticed part of the legislation talks about a 6-year cycle, or contracting authority that allows you to enter into contracts with various companies to provide these benefits for up to 6 years, for CMS to do that. Why can we not require, or why should we not require in this, that companies that want to participate in this stay with it for 3 years, or 4 years so we do not have the same kind of volatility we have had with Medicare+Choice?

It has been a real problem in my State, just as it has in Senator Daschle's, where companies come in, they have advertised. This one company came in and had this great motto which I remember. It said, "Health Care for Life." Everyone signs up. They want health care for life.

That sounds like a good plan, so they join their Medicare+Choice plan. Six months later, they send out a letter saying, we are pulling out of New Mexico, you are on your own. That caused a lot of consternation among seniors. It seems to me we are setting up sen-

iors for the same kind of situation with regard to prescription drugs.

Mr. SCULLY. Well, I think there are a couple of answers to that, Senator. We did not send up the details of our plan, but I will say that during the development of it—and I do not think this is in the plan. I cannot remember—we had envisioned actually 2-year contracts. We are happy to talk about that.

The committee has one, and I think that that can be discussed. We think this is fundamentally different than Medicare+Choice. Medicare+Choice, which is the HMOs, is county by county.

Plans frequently popped into one county, or left, or came in depending on the Federal reimbursement rates, which have been not working very well, and I think are poorly designed.

In this case, you have to take one-tenth of the country. One of the reasons we think there is going to be intense competition, is the average hospital gets 40 to 45 percent of revenue from seniors. So if you are in New England, for instance in Senator Jeffords' State of Vermont, if you want to take Vermont, you have got to take all of Massachusetts, all of New Hampshire, all of Maine, all of Rhode Island, you have got to take Connecticut, the entire area. You have got to take everybody.

So, we believe there is going to be intense competition, because for a big insurance company, a Blue Cross, a CIGNA, or an Oxford, where I was on the board for years, to take the risk of not getting that bulk of seniors when they are negotiating the next set of rates with doctors and hospitals is very dangerous.

So, we believe that the design that makes these 10 regions—if you are in New Mexico, you have got to bid on New Mexico, Arizona, California, and Nevada, I believe. I may be wrong. You have to take everybody in all those States. You cannot cherry-pick counties. So we think it would be much more attractive.

We think the plans are going to get in and stay. In fact, we think the plan's number-one complaint—and I can tell you the insurance companies' number-one complaint, is the people are very afraid that, if they are not one of the top three, they are going to get very hurt in the market.

But that is precisely why we designed it that way, to make the competitive bidding very intense for people to get in, get a piece of the Medicare, what is effectively a fee-for-service Medicare program.

Senator BINGAMAN. Can I just do a short follow-up? If we think it is this attractive to these companies, why do we not require them to stay in for three or 4 years instead of 1 year?

Mr. SCULLY. That is certainly something we would be willing to discuss. As I said, we had envisioned two, potentially. We would be happy to talk to the committee about that. I think that generally insurance conditions change. Also, the nature of competitive bidding is, if you re-bid it every one or 2 years, you are probably going to drive down prices.

If you lock on the same price for three or four years, we actually believe—and our actuaries believe—that the competitive bidding will drive down prices and I think three or 4 years might be too long. I think one to 2 years, we believe, might be right. But that is something we are certainly open to discussing.

Senator BINGAMAN. Thank you.

The CHAIRMAN. Senator Thomas?

Senator THOMAS. Thank you, Mr. Chairman.

I, too, want to comment on the rural health aspect of it. I am Chairman of the Caucus on Rural Health in the Senate, and we are very supportive of that and want to work with the House to cause that to happen.

Mr. Scully, I do want to say that there is a difference in the way the so-called PPOs operate in rural, as opposed to urban, areas. It seems like all we talk about is PPOs, but really they are not structured as PPOs in the rural areas. Is that not correct?

Mr. SCULLY. Absolutely.

Senator THOMAS. So this idea that they are not there, therefore you do not get service, just is not true. You go with your Federal employees' thing. They get service. So, I would just like to say that that is not going to keep people from being served.

I guess many of us have gone into this with sort of a vision that, over time at least, giving choice to all those that are now in Medicare, that there be a second option open, and that it really become a better service.

Do you think there is enough incentive in this proposal in terms of the private delivery system to make a change over time?

Mr. SCULLY. I have not been able to examine the details. Obviously, the administration's proposal, we have a strong preference for that, it has a differential drug benefit, for a variety of reasons.

One of them is, we believe that seniors will be happier with the new option, that they are going to get a better-structured benefit that is more efficient, and providing an incentive to get them in there.

Part of the way it is going to work, is you have to have enough people in there in bulk to make the competitive bidding work. So we have to get enough people in the new Medicare system to have enough in each of the 10 regions to work. So we have some disagreements with this proposal.

We are very happy with the bipartisan cooperation and the momentum that is building, but I can say that we still have concerns. I hope that is a reasonable position to be in.

But let me just add one thing on the rural issue. One hundred percent of the hospitals in Wyoming and Maine are in the Blue Cross plan, so when you get outside of urban areas, PPOs essentially are fee-for-service.

Every hospital in Wyoming is in the Blue Cross plan, every hospital in Maine is in the Blue Cross plan, and I think over 90 percent of the physicians in both States. So, really, PPOs only really function as PPOs in urban areas. Once you get outside of urban areas, they are fee-for-service.

Senator THOMAS. That has been my point. I think we ought not to emphasize PPOs as much as we are delivering service in the private sector.

But I understand what you would like, you and the administration, and I join you in that. So you have not had enough opportunity to look at the details of this to see if you think there is a satisfactory amount of incentive to cause to happen what you hope will happen?

Mr. SCULLY. It is very complicated. We prefer to have a differential drug benefit, clearly. There are other ways to do it, to provide incentives to move behaviorally to get people to go into these plans.

There is a very complicated calculation in the way you set the benchmarks for what the Federal Government pays, but we just have not had time to examine it yet and figure out whether it will work or not.

Senator THOMAS. Some believe that there ought to be a deeming or there ought to be some sort of an arbitrary level set on the payments. How do you determine the payments then in these rural, let us call them, Medicare Advantage programs?

Mr. SCULLY. Well, generally, as you know, Blue Cross of Wyoming, or CIGNA, those plans already have contracts with all these doctors and physicians. They are already basically going to be set up in the market, which is the way they should be set. Better doctors, better hospitals may get paid a little more and the lower performing may get a little less, which is one of the problems with Medicare.

The deeming issue really was an issue with CBO to try to keep the scoring down. We would like, obviously, to have the market establish the prices, not the government. There are some markets where consolidation has been maybe too high among providers.

Senator Santorum left. We discussed one of his markets in Pennsylvania, where arguably the hospitals have consolidated so much that they could artificially drive up prices. There are some places where deeming might be appropriate, but generally we would prefer to have the prices set by the market.

Senator THOMAS. I see. That is the so-called benchmark that there have been some arguments on here on the floor.

I think CBO's numbers looked at the alternative, the Medicare Advantage, and indicated a very low percentage, 10 or 11 percent, that they thought would go into that. You do not agree with that?

Mr. SCULLY. It all depends on the structure of the plan. If you set it up where you have the same drug benefit in the new Medicare Advantage as in the old plan and there are no other incentives, I think CBO probably—and we would probably agree—would say Medicare HMOs would grow a little bit back towards where they were, about 15 percent, and the PPOs would only draw about 11 percent. Under the President's proposal, the way we designed it, would probably have about 35 percent of the population.

Senator THOMAS. I know it is a little unfair because you have not had the time. But my question really is, do you think then that there ought to be something done differently in the proposal to reach the effort that you want to to get more people into that voluntary plan?

Mr. SCULLY. Well, again, our clear view in the President's proposal was, and we knew it was going to be controversial and we knew it might be difficult, and we did it consciously, we thought it was the right policy. We thought the right thing to do in the traditional program was a catastrophic-only benefit for free.

Every senior would have gotten catastrophic stop-loss in the old program with no additional costs. If they went into the HMO or the fee-for-service PPO, they would get an additional subsidy that was

roughly twice the value, but they would also have to put their own money in as well.

In the ballpark of this chart, we did not put up numbers, but since this is the mid-range of the House and Senate, theoretically, if you had a \$1,200 drug benefit, the senior would pay \$400 and the government would put in \$800 under the construct of the mid-range of what these bills are and we give a bigger drug benefit, in addition to additional beneficiary payment in the new programs, and that would be enough to incentivize more people to go in. That is clearly our preference, but we are trying to work within the process.

Senator THOMAS. All right. Thank you.

The CHAIRMAN. Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman. I want to thank you and Senator Baucus for your Herculean efforts in bringing us to this point to provide a long overdue benefit for seniors.

I would like to continue to follow-up on the issue of PPOs as an option in delivering an integrated benefit, including prescription drugs.

Now, you have said that PPOs are in rural communities, and that doctors in rural communities all participate in the network. But there was a report that was released yesterday by Public Citizen that indicated that is not the case, that not all doctors are in PPO networks. They reviewed five States. It is interesting to look at, including the State of Maine, where a number of doctors do not participate in a private network.

They participate in Medicare, but they do not participate in a private network. I think the issue here is, obviously, it should be an option I think we ought to explore. But, obviously, it is also important to ensure that we preserve the integrity of the traditional fee-for-service, and also gets to the issue of having an equal or unequal benefit in terms of prescription drugs available and all the options.

I know you have said that there is a benefit with an unequal benefit. Now, if that is the case, and you are saying, for example, that under your options that CMS actuaries had said that 30 percent of seniors would choose the PPO option, another 14 percent would choose the HMO option, so there are 54 percent that obviously would stay in the traditional fee-for-service.

Obviously, that would have an impact on those seniors because if they have a less attractive prescription drug benefit, that obviously is going to affect their well-being, when seniors that have five or more chronic illnesses account for more than 65 percent of Medicare costs.

So if the incentive is to draw them into the PPO model for the prescription drug benefit because it is a better benefit than exists under the traditional fee-for-service, then obviously it could result in having the sicker people going into that option and the healthier one staying in the traditional fee-for-service.

Mr. SCULLY. Well, I cannot speak to the committee's specific design, but I will say that in the administration's design we based the premiums from the old Medicare program on the 2004 population and froze it there, so that if it turned out that older people stayed

in the old Medicare program and younger people in the new one, traditional Medicare would be preserved as it is indefinitely.

So, we try to make up for that potential for what is called risk selection. We just basically believe, and as I have tried to show in these charts, that seniors will be much better off because they will have more integrated benefit.

Having three separate plans, Medicare, a non-community-rated Medigap, and a non-community-rated drug benefit is not going to be as efficient a package as a combined package. I believe the actuaries may differ. I think people are going to find this to be much more attractive.

But we clearly want to preserve traditional Medicare. If somebody in rural Maine wants to have traditional Medicare forever, we are all for that. Again, as I said in our proposal, and I know you do not agree with us on the drug differential, we would give, again, let us just say in the range of a \$300 to \$500 free catastrophic benefit over what they have now. So everyone, including people in traditional Medicare, would get substantially more benefits than they have today.

Senator SNOWE. But the risk is from not only the standpoint of providing a less attractive option in the traditional fee-for-service. I mean, if you pursued that approach, then it ultimately could run the risk of denying people the kind of coverage that they deserve if they go to a PPO option, and that is an attractive option in terms of the underlying integrated health benefit. I mean, that is a big difference here.

I am concerned, obviously, about the availability of the PPO networks in my State, which is essentially a rural State. It has no Medicare+Choice option. I think it is a good idea to explore a private dimension, but to do so exclusively in some way or to make the prescription drug benefit more attractive in that option as opposed to the traditional fee-for-service runs the risk of putting people in a plan where the network might not be available and might not be as attractive.

I am concerned with this report that indicates that a lot of doctors do not participate currently in the private networks, so they will not be available.

Mr. SCULLY. The information I have—and I occasionally agree with Public Citizen. I cannot remember the last time I did, but I must have at some point.

Senator SNOWE. Are you aware of the report?

Mr. SCULLY. I did not see it. I saw the press release yesterday. But 90 percent of doctors in this country participate in Medicare are Medicare-participating physicians, and 92 percent participate in some type of PPO. So there is always going to be a certain number of doctors. I mean, I understand the issue and I totally agree with you.

For instance, my deputy medical director, I hope you will be happy to know, I just hired from Bangor.

Senator SNOWE. Good judgment.

Mr. SCULLY. Very good judgment. We have talked about this with a lot of physicians on my staff and in other places in rural areas. We clearly are going to preserve the existing Medicare op-



tion. But I really believe that in most areas, in most rural States, this coverage is widely available.

Senator SNOWE. Well, I would love to have your data to show exactly how PPOs would be available in rural areas specifically.

Mr. SCULLY. I would be happy to.

Senator SNOWE. Because I think we need to have access to that data to highlight that issue. But I do think it does run the risk, without preserving the traditional fee-for-service, including having the same benefit.

Mr. SCULLY. In most States, the Blue Cross plans—and there are the CIGNAs and other plans, too, but Blue Cross is the biggest—in rural areas it is basically a fee-for-service system. There is no PPO. Everybody is a contractor.

Senator SNOWE. Right. Thank you.

The CHAIRMAN. Senator Nickles?

Senator NICKLES. Mr. Chairman, thank you very much. I want to thank you for having this hearing. I appreciate the information we are getting. I wish that we would have had Heritage participate in the hearing. I think I asked for them. Maybe I should have asked more forcefully. But I think the hearing is helpful.

Let me ask you, Mr. Scully, and Mr. Chairman, so you will know, I am very interested in passing a bill, but I also want to make very sure that we pass a bill that accomplishes every objective that I have heard, but also is going to be affordable and sustainable for future generations. I am worried about that. I am very worried about it.

Mr. Scully, what is the unfunded liability that we have right now on Medicare? Is it about \$13.3 trillion?

Mr. SCULLY. I think it is a little above that, yes. Close.

Senator NICKLES. And is that not about two or three times the unfunded liability we have in Social Security?

Mr. SCULLY. Yes.

Senator NICKLES. I think OMB, where you used to work, did analysis of the budget and said that the plans that were proposed last year and actually passed the House, and the House Ways and Means would have increased that by \$4.6 trillion, and Senator Graham's proposal would have increased that by \$6.9 trillion—not billion, trillion—is that not correct?

Mr. SCULLY. I am sure that is correct.

Senator NICKLES. And the \$4.6 trillion that passed the House happens to be the same unfunded liability in Social Security. We are talking about trillions of dollars, and that is over a 75-year period of time. So, most of the drug proposals we are talking about add significantly.

Would you and/or your actuaries give us an estimate on how much this would increase the unfunded liability on Medicare as well?

Mr. SCULLY. Yes, we will, Senator.

Senator NICKLES. I would appreciate that.

Mr. Chairman, that means a lot to me. I have mentioned before, just to our colleagues, I found it interesting, Senator Bingaman's comments, and the Urban Institute is testifying they can justify their own chart.

Mr. Scully's comment was, well, I am sure that we are subsidizing low-income a lot, and we are. We are providing new benefits, correct me if I am wrong, but I believe for about 40-some percent of Medicare recipients that would have anywhere from 80 percent to 97.5 percent of their drug costs covered, period. Correct me if I am wrong. Mr. Chairman, you and/or staff correct me if I am wrong.

Let me ask you, what is the percentage of Medicare recipients that are less than 150 percent of poverty?

Mr. SCULLY. About 25 percent, I believe.

Senator NICKLES. I believe it is much higher than that. I would like for you to answer that for the record.

Mr. SCULLY. I will.

Senator NICKLES. I think it is closer to 48 percent, if the chart I am looking at is accurate. If it is not, I would love to know.

Senator BREAUX. It is not anywhere close to that.

Senator NICKLES. I am looking at a chart that has it broken out by group and I am adding up those groups. Again, I would love to be corrected.

Mr. SCULLY. I will check for you, Senator. I think it is about 11 million people, but that is just my memory.

Senator NICKLES. Well, I would like to know each bracket, the number of people. Because we are talking about subsidizing these, anywhere from 97.5 percent to 80 percent, all the way up to 150 percent of poverty.

Those are enormous subsidies, new subsidies, brand-new subsidies that I will almost venture to say, and I will guess, that CBO is going to underestimate how much it is going to cost, because I think utilization, if you are paying anywhere near that kind of a subsidy rate, will skyrocket.

Let me ask you another question. You mentioned that the advisability of having an integrated drug benefit with the entire plan, such as we have in health care plans that are in the private sector, in Federal employees, and so on, if you have a drug-only benefit under Medicare as proposed as a separate benefit for fee-for-service under existing Medicare, is there any mechanism to where that would be coordinated? You mentioned possibly having a relative that might have numerous tests done by different doctors, or seniors that are beneficiaries going to different doctors.

Is there any coordination of that care to prevent a lot of duplicating, maybe even a dangerous combination of prescriptions?

Mr. SCULLY. Well, I think that is one of the benefits. Some people have problems with PBMs, but there are pharmacy benefit managers and they cover 200 million Americans through commercial insurance.

Senator NICKLES. I am not talking about commercial. I am talking about, in the first place, is there a drug-only benefit insurance now? Has that product been offered?

Mr. SCULLY. In Medicare? Very limited. Pacific Care has started to talk about doing one. They are the only ones I am aware of.

Senator NICKLES. No one is doing it. My point being, if you have fee-for-service Medicare, and basically you drop by the doctor and you check the box and you are paid, that doctor can order prescriptions, and they can go into another doctor, a different specialist,

and they can order prescriptions, and there is no real coordination. I am concerned about that under this proposal. I think that could happen. I also think it would be dangerous.

I think you could have seniors that have a lot of different prescriptions. I frankly think it may be happening to some extent today, but it could happen even more so if Uncle Sam is going to be picking up anywhere from 97 percent, to 80 percent, to 50 percent, depending on which income level a beneficiary might be in.

So, anyway, if you could give me estimates on the number of people, the total subsidies, the breakdowns, and is there any coordination or cost containment over utilization on the drug benefit, I think I would appreciate it.

The CHAIRMAN. Well, if you want to respond, then I will call on Senator Lincoln.

Mr. SCULLY. Just briefly. I would say one of the benefits we think of the fee-for-service PPO model, is that most of the people who participate in that, as they with our own plans in the Federal employees' plan, would be PBMs. They do manage benefits. They do generally provide formularies to decide how to negotiate prices, and they are relatively efficient.

The other alternative, which scares me to death, to be honest with you, is to have my agency fix prices for Lipitor and Celebrex, and all these other prices, and have the Federal Government try to determine, in a very political system, what those prices are. We already have a model for that. On the outpatient side of Medicare, I spend \$8 billion a year on drugs.

By virtually all accounts, we pay 25 percent more than we should be because we do it in a very inefficient, very politicized price-fixed mechanism which we do not think is a good model for the rest of Medicare.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. Certainly, I would like to thank you for starting us in on this issue and this journey, because we do know it is a very important one for the people we represent. It is a journey we have been on for quite some time.

I know that we have got some lofty goals in terms of trying to get all of this done in the next couple of weeks, and I hope that we can all dig in and try to do that. But I hope we will not miss any of the details.

Mr. Scully, we are glad to have you. We appreciate your availability, and certainly your willingness to work with us, and I look forward to working with you in the next couple of weeks.

I guess some of my concerns come from experiences we have had, as well as trying to put together some of these images of where we might be going. I guess I start with the disagreement of the difference of opinion that both CMS and CBO have on what private plans will save or will not save Medicare.

I guess we look, in Arkansas, at what has happened for us in terms of the private sector, particularly Medicare+Choice. Those payments are already 104 percent of the fee-for-service cost. Whatever we had in Arkansas left 2 years ago, and what we had then did not even provide a prescription drug package.

I guess, based on the study that the Center for Studying Health Systems Change shows that most of the areas across our country,

the private plans pay higher rates than Medicare, and that is certainly true in Little Rock, where I live, where private payment ranges from 120 to 180 percent of Medicare physician payments.

So I guess if that is the case, if health plans will not be able to buy health care for seniors at a lower price, why should we really be paying health plans to come in?

Mr. SCULLY. Senator, really, we do not think we should pay health plans more to come in, and we do not think we will be.

Senator LINCOLN. This plan calls for a 2 percent extra bonus payment.

Mr. SCULLY. I am not totally familiar with the structure of the Senate plan yet, but our structure did not. In the long run, we obviously believe that we are going to save money with PPOs. HMOs are significantly different.

I believe, personally, with the best of intentions, trying to push private health plans out in the rural areas of 1997, we changed the Medicare structure. HMOs generally work in urban areas, they do not work in rural areas, or even mid-sized areas. We have changed the structure, and I personally believe that it backfired in 1997, and that is the reason the formula has not worked.

Senator LINCOLN. PPOs can contract in Medicare right now, right?

Mr. SCULLY. They can, but they have to do it county by county. It is a totally different design than this. When you have to go and cherry-pick counties, it is much tougher.

In this particular case, which I think is much more modeled like the Federal Employees Health Benefit Plan, which has worked, and Tricare, the Defense program which has worked, you have to pick an entire region, and you cannot cherry-pick just Little Rock or other counties in Arkansas, you have to take the whole State.

HMOs are fundamentally different than the fee-for-service plan. This is basically a PPO. It is a much looser form of coverage. It is a totally different design.

I personally think that, in the mid-1990's, HMOs were growing in urban areas and doing well. With all the best intentions, on a bipartisan basis, people redesigned that in the hopes of pushing them out to rural areas, and that model does not work in rural areas and I think it backfired. But I think PPOs and the fee-for-service model we are talking about are fundamentally different.

Senator LINCOLN. So you think the reason that PPOs do not play in Medicare right now is because?

Mr. SCULLY. Because if you are a PPO, or HMO, you have to be able to go into a market county-by-county and develop a strong enough network to actually deliver in that county. People can cherry-pick counties and move around.

In this particular mechanism you are going to get one-tenth of the country, and you will be one of three insurers, and you will get huge bulk, which does scare a lot of insurance companies.

If you are not one of the three winners in your region, you are out of luck. I spoke to some insurance companies yesterday who are panicked about that, but that is precisely why we designed it that way.

That is one of the reasons we are worried about having enough people come in and incentivize a big enough population to come in,

is in a tenth of the country you are in, once you get a big enough chunk of the population of seniors to have enough market share to be able to go in and design a good plan. PPOs, in a very fragmented market, if you are going to come into the current system, really cannot make it.

Senator LINCOLN. But you think that this is going to provide them enough incentive to come into these markets, particularly like rural Arkansas? Not necessarily Little Rock, but about DuQueen or Laura?

Mr. SCULLY. I think if you talk to the Blue Cross plans, they have also been very disappointed with Medicare+Choice. They are nervous about the past experience, too.

But I have talked to the CEOs of all of the top 10 companies and a lot of the Blue Cross plans. I believe in Arkansas, I checked, 100 percent of the hospitals in Arkansas are in the Blue Cross network, they have a PPO also in the State of Arkansas.

I believe it is the primary source of insurance in Arkansas, and it works for people under 65. We think we are going to piggyback on that. There are four or five other fairly large carriers in Arkansas.

I think if you do it State-wide and you make sure everybody is in at a community rate, it is much more likely to work. The current system is much more fragmented.

Senator LINCOLN. So do you think we should have an extra bonus payment of 2 percent in order to get them in there?

Mr. SCULLY. That really comes down to the fundamental difference, which is very arcane, and I will explain it if you like, between CBO and OMB. We believe that you are not going to need that and it will save money. CBO's estimate is they will cost more, and you want to cap that spending.

The committee made the decision that if CBO is right and that it will cost more, that they are not willing to spend more than 2 percent more. We actually believe that they are going to cost less and be 1 percent less.

So, we are happy to go without that, but the committee has to live with CBO scores. CBO says it will cost more and they have basically put a lid on how much more it will cost.

We would be more than happy to take that off, but unfortunately the committee does not get to live with our scoring, they get to live with CBO's.

Senator LINCOLN. If I could just tag onto what Senator Daschle said, and that is, quickly, when you talk about these fall-back plans, the government fall-back plan, for instance, if we have the same scenario we had with Medicare+Choice and you have got two private plans, then all of a sudden they leave, you have got the government fall-back plan that comes in and then others come in, and then the government fall-back plan has to come back out, you have got seniors that are making decisions year to year with total confusion, which means that more than likely, if they are going to have all of these different plans coming in and out, that their prescription drug package is going to change, what is covered is going to change, and probably their premiums are going to change, the doctors they can see are going to change. All of that is going to

change on a year-to-year basis for our seniors, it sounds like. It sounds like a lot of confusion for our elderly.

Mr. SCULLY. Well, actually, believe it or not, Senator, with all due respect, it will be less confusing, and I think for a couple of reasons. One, is we will always have the ultimate fall-back, which is the Medicare traditional program. As far as we are concerned, it will always be there and never change, so any senior in Arkansas who wants to have that forever can have it.

But, second, if you look at what seniors in your State look at, they get Medicare, which converse 60 percent of their benefit costs. Then they go out and buy Medigap on top of that, which is usually a very poorly structured plan.

The only one I know that is community-rated is the AARP, the rest are not. They are very poorly-structured, not community-rated plans. They are not very efficient. On top of that, they are going to buy another private drug plan.

We are happy to go with that, but we think that when your seniors look at it, many of them are going to have a much simpler choice: I want to buy the Arkansas PPO from Blue Cross, or the CIGNA PPO. They are not going to be forced to, but we think they are going to get a much more efficient, consolidated benefit, much less confusing. I think most people, if you ask them, that are 64 and in an Arkansas Blue Cross plan, find it far less confusing than the Medicare plan plus their Medigap plan.

Most seniors, including my parents, I can tell you, are incredibly confused by their existing hybrid of not-particularly-well-structured Medicare plans. They love it because Medicare covers everybody and it is a social insurance program that is community-rated and covers everybody, and that is the magic of it. But Medicare itself is incredibly confusing to most seniors now.

Senator LINCOLN. Thank you, Mr. Chairman.

Senator NICKLES. Mr. Chairman, could I just make a comment?

The CHAIRMAN. Senator Rockefeller, Senator Nickles would like to correct something before you ask your questions.

Senator Nickles?

Senator NICKLES. Mr. Chairman, thank you.

I have got some information from HHS, Mr. Scully, and I used 48 percent. That included people in the category of 150 to 175, that is, 8 percent. But it does mean that there is 40 percent who are at 150 percent or below.

Just so everyone knows, the subsidies for this group are very large. They go all the way from 97.5 percent to the maximum co-pay, which would be 10 percent for the 135 percent, and 20 percent. Still, that is enormous. That is enormous. It means the most anybody would pay in that category would be 20 percent of their drug costs.

The CHAIRMAN. All right.

Senator Rockefeller?

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

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I am going to save most of my questions for Marilyn Moon. One of the reasons is, I have discovered that over the years, in my

friendship with Tom Scully, that he can talk himself in and out of any situation, regardless of what the facts are.

That is made more complicated this morning by the fact that he does not know what the facts and the program are, so there is sort of a double jeopardy in even attempting to do that.

Second, I need to just say for the record—and I recognize I was late in coming in—that I have never really quite been through a process as bad as this, as Kent Conrad indicated, in the 17 years that I have been on this committee on a program which is so important.

It has been said, I am sure, before, but it needs to be said again because it is what is affecting me as I think what is going to happen to my seniors in West Virginia.

This was not really a bipartisan situation. I am Ranking Member of the Health Subcommittee, and I never was in on a single meeting where substance was discussed, only when the Chairman of the committee was asking, what are people's views, which is a technique which we have used a lot around here, what are your views, what would you like to see.

But then, even during that conversation, there was a lot of discussion from both sides about, nobody really had any idea that there were anything more than concepts, there were no facts, there were no plans, there was no paper. The staff met afterwards and there was even less then.

So we are passing a plan which you indicate that we sort of all know what the basic facts are, but in fact we really do not. We really do not. For example, my guess is, we are putting probably between \$20 and \$25 billion into inducements, or bribery, or whatever you want to try to get private plans into States like West Virginia where they do not exist at all now, and where they will not exist with the bribery.

That happens to equal the entire amount of money that we put in for fiscal aid to the States. My guess is, if we did not do that and if we did not try to bribe or induce private plans to come into West Virginia where they will not come in any event, that we could probably lower the premium for Medicare beneficiaries by about \$5.

Now, are we at \$35, \$25, \$50, as Kent Conrad said? Nobody seems to really know. But my guess is, we could probably do it by about \$5, and that is one of the questions I am going to ask Marilyn Moon.

I am really stunned by this and I am profoundly hurt and worried for the future of the seniors of my State. Our average income is not, as is talked about in FEHPB, an average of \$41,000 with relatively healthy people who are still, many of them, working. But the average income in my State, gross income for Medicare beneficiaries, is around \$10,800.

That creates a very different set of expectations, much greater dependency, much greater dependency on constancy, much more worry there about the thing that Senator Lincoln was worried about, and that is people sort of coming in, getting out, coming in, getting out as plans either do or do not arrive.

I do not think you can guarantee me. I think you can give me the words that there will be equal benefits for California, West Vir-

ginia, or throughout the country, but I do not really believe that. I do not believe that is going to be the case.

I am not sure that you know. I am not sure that either the Chairman or the Ranking Member of this committee knows the answer to that. So the FEHBP model is one that really has never turned me on, I have said it a hundred times in this committee, because it is not relevant to the State that I represent.

I basically think that people, as they get older, they get worried, they get scared, and many of them are isolated. There are nine million Americans who live all by themselves and are either looked after or called upon by their neighbors, or not. I think that a sense of confidence in the system is often as important as the system itself.

I think what we are doing is taking a system which is very efficient and, for the sake of edging towards the privatizing of Medicare—and I believe that is what this is.

I mean, I think it is a free enterprise effort to enter into the Medicare market, regardless of what the effects on the beneficiaries are. I am not against the private sector, but I care very much about what the effects are on the beneficiaries in my State.

My fear is that they are going to end up as they are now, with Medicare+Choice, which represents less than 2 percent of the people in my State, not one single plan. So a lot of money is being spent to put plans into, let us say, Eastern Massachusetts, where they will work very well. They certainly will not in Western Massachusetts, but others have decided that that is all right.

But in my State, it is not. I am very angry about this process. I am very angry about what I perceive or guess to be this product, on behalf of the people that I represent. I think that they are not going to know what it is. In that case, they will be entirely similar to us: they do not know what it is.

We are having a hearing. The hearing was called two days ago, I guess, for today. We will mark it up next week. We will not really have any idea what we are marking up. It is the most extraordinarily bad way of doing business that I can think of, and I am embarrassed by it, I am ashamed by it.

I worry tremendously for the people of my State who depend upon Medicare, which costs 2 or 3 percent to run, which is not over-paid, as the Senator from Arkansas indicated by private plans, which is not subject to inducements, which is a public program which people do understand.

I have always felt that what you do if you want to reform Medicare and make it work better, is you take Medicare as it is and you add on a prescription drug benefit.

I had a very good solution to that which I gave to the AARP executive board, and then I will finish, Mr. Chairman. That is, you take the double taxation of dividends, which was scored at about \$397 billion, and you add it on to the \$400 billion which was put in for Medicare, and then you could call it the George W. Bush prescription drug program and I would be entirely happy with that.

That is fine, and he should take full credit for that. But we did not do that because people here wanted to have that deduction, which does not affect the people of my State very much. So, we passed up that opportunity.



I have a high regard for you, Tom Scully. As you know, you have done many things to help my State. You had a different approach, I think, than this committee came out with, whatever this committee is coming out with.

But I want to express just a very profound sense of sadness and dissatisfaction and worry on behalf of the people I represent.

The CHAIRMAN. Senator Hatch?

Senator HATCH. I have been interested in these comments, because we just heard from the Budget Committee Chairman who says that we are going to be spending an awful lot of money helping the poor. There are also dual eligible people who will be helped, regardless.

Second, last year I was a member of the five-Senator tripartisan group who put together the tripartisan bill. We had scoring on that. We knew where we were going and I think could have put it through last year.

In contrast to the Graham-Rockefeller bill, which had no hearings, had no scoring and was brought to the floor, in all honesty, this process is far superior to what we went through last year with regard to prescription drug benefits.

So I want to personally congratulate and compliment the Chairman and the Ranking Member, Senators Grassley and Baucus, for being able to bring this together. There is no simple, easy way to do this. As much as I was strongly for the tripartisan bill last year, I think this bill is an improvement on that.

I want to compliment the administration for being willing to force us into doing this. We can always say that this bill could be improved if we had trillions of dollars with which to do it.

We could improve anything if we had unlimited funds. But this is going to be a costly bill. It is going to be a worthwhile bill. I hope that the private sector part of this works well, and I believe that it will.

Let me just ask you a question on that. Senator Frist mentioned the administrative costs and inefficiencies associated with traditional Medicare. Now, could you tell us more about how Medicare Advantage will decrease these costs and thereby improve the care for the various beneficiaries who receive the care?

Mr. SCULLY. Well, we think this is tied into the whole gradual improvement of the health care system. The great thing about Medicare is it is a universal coverage plan that covers everybody.

I think the problem we have with it is, it pays every provider, every doctor, every hospital in the country at exactly the same rate and it does not incentivize quality.

As you know, we have started measuring nursing home quality in the last year, measuring home health quality in the last year, putting ads in every newspaper in the country.

We believe giving consumers a lot more information and having a more information about providers and paying them at some point relatively based on quality, which the private sector tends to do a lot more of, is going to improve health care across the country.

The great thing about Medicare, is it covers everybody and does not leave anybody out over the age of 65 or who is disabled. The danger of it is, we have basically a centrally managed system that is inefficient.

As I mentioned earlier, we do things like hospital outlier payments where we paid \$2 billion a year for four years in a row that we did not really understand that went out the door.

That is 2 percent of all hospital spending that we did not even know existed 4 years in a row that we did not catch because we have a very centrally run system out of Baltimore that is wonderful, but it is not particularly efficient.

We believe that having local Blue Cross plans, local insurance companies that are more sensitive to local markets and have a better understanding of what is going on, who are the better providers, who are the lesser providers, and more of an understanding of the utilization of health care is going to be much more efficient.

Can I just add, quickly, because Senator Rockefeller is an old friend of mine and I know he is not very happy with it, but I really do think we have worked on this, as we have, Senator Hatch, since 1989. I think we spent time trying to avoid having a drug benefit repealed then.

This really is the best opportunity we have had to fix Medicare and add a drug benefit in 15 years, at least. I really do think, and I hope we can convince Senator Rockefeller, as unhappy as he is with us today, that I really do think this is the right thing to do, and I hope we can work with all of you going forward on a bipartisan basis to get this done.

Senator HATCH. Thank you. Could you please talk about the dual eligible low-income component of this bill? For instance, does this legislation not take into account the serious budget issues that States are facing? And could you please talk about this in a little more detail?

My State of Utah contacted me last night and wanted to know just how this is going to affect them. If you could just give us a little more knowledge on that, I would appreciate it.

Mr. SCULLY. Obviously, I do not know the details of how the Senate plan works. Obviously, we are concerned, as Senator Nickles said, about the scoring and what it costs.

But I will say that under the structure of the administration's framework, and when we looked at it, the money is heavily, heavily weighted towards low-income people and we probably help people in States like West Virginia that are lower income enormously.

The average low-income beneficiaries under most of these plans is looking at about a \$3,000 per year very thorough drug package. The people who may not be as happy as you get into the details is as you go further down the income stream because they do not get covered as much. But every package I have looked at, the administration's framework, the Senate, is very heavily weighted towards low-income beneficiaries.

Senator HATCH. Thank you.

Just one last question. I am also interested in hearing more about how we are reaching out to the employer community. I know that the Finance staff has worked very carefully on the employer issues and we have made pretty good progress, I think. Could you talk about how an ideal policy would encourage employers to continue providing drug benefits for their retirees? Because I am concerned about that.

Mr. SCULLY. Senator, I cannot tell you. I do not know how the Senate did it. It is a very delicate balance. Obviously, if you are in a retiree health plan and you are at ALCOA or something and you are already in a plan where ALCOA is paying for your drug benefits, it is not in our interests to go buy out what companies are spending on their retirees already.

On the other hand, it is voluntary and they can dump them on the Federal Government anytime they like. So the transition of subsidizing companies' existing plans enough to keep them in without having to take scarce resources and buy out large corporate retiree plans is a delicate balance that we have spent a lot of time worrying about, and I am assuming the committee is also looking at the same thing.

So, we want to maximize the drug coverage, the new spending, on new people, not people that are already covered. How you do that is pretty dicey. It is doable, but it is a very sensitive policy and we are very interested in working with the committee to make sure we do that the right way.

Senator HATCH. Thank you.

The CHAIRMAN. Thank you, Senator Hatch. Thank you, Mr. Scully.

Senator BAUCUS. Mr. Chairman?

The CHAIRMAN. Yes, Senator Baucus?

Senator BAUCUS. Mr. Chairman, thank you very much. There have been some very legitimate concerns here about the amount of information and timing and process and so forth, and I very much understand that.

It is almost always a concern around here. I might just point out though that there have been many hearings on this subject, maybe 20-some hearings, I think. But unfortunately, a lot of Senators just do not come to the hearings. We call hearings and not many people attend.

But, more importantly, I have insisted that we get the CBO scores in advance of putting out any mark, and insisted we get a process where CBO scores amendments, too. I am not quite certain how we are going to do all that with a bit of a time constraint.

This process, frankly, is much better than some other times when this committee has considered other legislation. Sometimes a tax bill is rushed through. We have the Joint Tax revenue tables that are just suddenly thrust upon us just before a mark-up. That has sometimes happened, I think, probably on both sides of the aisle. Maybe you did not have a distribution table for the tax bill that left the Senate floor. Usually this committee has a distribution table, or at least it has in prior years.

So, I appreciate those that have some concerns, but I think that this is very orderly. I might also point out that it would probably be a little bit misleading to put out precise provisions and numbers before we get CBO scores, because CBO is going to probably cause us to make an adjustment, a change here and there, or we may see some more opportunities that we did not earlier see.

So, we are trying, the Chairman and I, to be very orderly and very respectful of everyone, members of the committee, the public, and I just think the procedure we have set up here at least is an

attempt to be very fair to everybody. I think, compared to other instances, it is quite fair.

Senator HATCH. Mr. Chairman, could I just ask one short question that I do not think has been asked, but might be very important?

The CHAIRMAN. If we can have a short answer, because we promised our other panel that we would be very quick. Go ahead.

Senator HATCH. All right. Thank you.

We have heard concerns that PPOs will not be available in rural areas. These concerns have been expressed here today.

Now, does this plan that we are proposing here not combine rural areas with urban areas, and does this not help to ensure that rural areas will have PPOs?

Mr. SCULLY. To be one of the winning three bidders, at least under our construct—it may be slightly different in the committee's—in any of the 10 regions we have broken the country up into, you have to take every place. So if you want to get Salt Lake City, you have to take the entire State of Utah.

Senator HATCH. That is my understanding. That is why I wanted to clarify that for the record. Thank you.

Mr. SCULLY. Yes.

The CHAIRMAN. Thank you. Thank you, Mr. Scully.

Mr. SCULLY. Thank you, Mr. Chairman.

The CHAIRMAN. Now, I have already introduced the second panel. Would you please come, Mr. Francis and Ms. Moon? I do not think Ms. Moon heard me say that I had an opportunity to meet her several years ago when she appeared at a forum that I had in the State of Iowa, and I welcome you back again.

I think the way I introduced, was Mr. Francis, then Ms. Moon, and I think we will go in that order.

So would you start out, Mr. Francis? For both of you, I know you have longer statements. They will be included in the record without your asking. Then we, of course, ask you to summarize.

Proceed, Mr. Francis.

**STATEMENT OF WALTON FRANCIS, AUTHOR AND  
INDEPENDENT CONSULTANT, FAIRFAX, VA**

Mr. FRANCIS. Thank you very much, Mr. Chairman. It is something of a hard act to follow Tom Scully, then to have as distinguished an analyst as Marilyn Moon behind me, but I will try to focus on the issues and questions that I think are of most concern to this committee as it finishes drafting the legislation.

I also want to commend and congratulate you for doing this. I think you are building on work that Senator Breaux so ably began several years ago, and we all hope that you will succeed.

But the danger here is that, while we do not want to let the good be the enemy of the best, we do not want something worse than merely good.

I am going to suggest some issues that I think you ought to focus on as you make final decisions, first in your committee product, later on the floor of the Senate, and finally in working with the House in producing final legislation.

I would like to talk about a few aspects of the comparison between FEHBP and Medicare performance that are most salient to

what you are addressing. I will not, for example, talk about the benefit superiority of the Federal Employees Health Benefit Program. It is obvious and does not warrant discussion, really.

I want to talk, first, about evolution of change in that program. You are talking today about enacting something that will include a catastrophic coverage benefit, prescription drug benefit, and add preferred provider networks to the Medicare program.

All three of those innovations occurred painlessly, without political fuss or furor, over a period of decades in the FEHBP. That is sort of a sharp contrast in models.

Fifteen years ago, there were virtually no PPOs in the FEHBP. Today, almost every national plan operates a dual structure: fee-for-service if you go out of the network, and you will have to pay more, and a preferred provider network.

They have developed that way to save money, improve service, preserve availability of provider choice, and attract customers in a consumer-driven, market-driven model. It is a near total absence of top-down legislation or management.

The basic FEHBP statute has not been substantively modified in 40 years, whereas, as you know, your committee produces a near telephone book of changes to the Medicare statute just about every year.

So, there is a danger here. The danger is to over-design. We have a program which, while ably managed in some respects by the Office of Personnel Management, at its core, all the important decisions are made by consumers and by health plans trying to attract consumers, and it works.

Cost. This is a significant issue and I think it is particularly unfortunate that CBO is apparently going to be quite, conservative is hardly the right word, in its scoring of PPO performance.

Marilyn has worked on this subject in a more general way, and I am sure she will talk about it. I have made specific comparisons—they are in my testimony, I will not go into the details—showing how FEHBP and Medicare cost controls compare over time.

The short answer is, they are virtually in a dead heat if you just look at costs. FEHBP has maybe outperformed Medicare slightly. It all depends on what period you pick, though. In the last few years, Medicare has done better.

Based on what we have all heard about what is happening right now, probably by the next year or two FEHBP will be back in the lead. But if you take into account benefit improvements in these programs and the fact that the FEHBP has had to deal with controlling the costs of prescription drugs, an issue that Medicare has not had to face, I think there is no question that the FEHBP has outperformed Medicare.

That is despite the fact that its administrative costs are higher, et cetera, et cetera. In fact, it is in part because its administrative costs are higher, because these plans manage care in a way that Medicare simply does not.

Finally, there is the whole issue of access. That is obviously weighing heavily in your minds and I discuss it at some length in my written testimony. There is no question that the preferred pro-

vider networks and the FEHBP provide excellent access in rural areas throughout the country today.

I learned yesterday of a new Public Citizen study, and thinking it might come up today, got ahold of a draft copy. I spent a little time on the Internet last night. I want to tell you that, until last night, I had never heard of Franklin County in Maine, with perhaps the largest town being a hamlet called Gardiner.

So I pulled out this Public Citizen study and it says basically there are not any doctors participating in preferred provider networks under the FEHBP in the county. That is basically their conclusion. They do that for a number of counties, including one in West Virginia, which I will discuss in a second.

Well, I simply got on one of the preferred provider networks on the Internet. By the way, this is a homework assignment I urge on all Senators and all staff here today. Just go to any FEHBP plan web site, poke in your hometown, or your grandmother's hometown, or wherever you like, and ask, how many participating providers are there within five miles? The answer will probably be zero, or close to zero.

Then you click the next button and say, how about 20 miles? Now the number will start getting bigger. Then you say 50 miles, and you have got a big number. The answer happens to be, in Franklin County, that there are 100 participating preferred providers within 20 miles of that town, and over 300 within 50 miles.

Similarly, Pendleton County, West Virginia, the town of Franklin. There's nobody nearby.

Senator ROCKEFELLER. What was the county that you mentioned?

Mr. FRANCIS. Pendleton County.

Senator ROCKEFELLER. Oh, you got it right.

Mr. FRANCIS. It is in Southeast West Virginia. It turns out that within 36 miles of Pendleton is the city of Harrisonburg, Virginia, and that is where, obviously, the people from Pendleton go to get their health care, because that is where all the doctors are. So you cannot do a study that just simply stops at county lines and ignores health care markets and where people go for their care.

I will just pass over that. I do not want to talk more about that issue. I am happy to answer more questions about it.

Turning to Medicare reform, in the FEHBP program, the government is a good business partner. We need merely look at Medicare+Choice to know that Medicare does not have a good track record as being a good business partner.

Stability, hands-off, not regulating, not micromanaging. Those are the kinds of design issues you have to face. You have to set up a system that will operate itself, if you will, with minimal government interference, or you are not going to match the kind of performance the FEHBP has.

Reasonable and predictable levels of financing, letting plans design the benefits, including the core Medicare benefit. They should not have to follow those Medicare drug pricing rules, or outlier payments, or any of that stuff that you foisted on the HMOs.

Let plans define service areas. This is a big problem. It can be done. You can require them to cover large areas. But if you constrain them, you will distort their ability to deal with health care

markets. You cannot avoid the problem that wherever you draw a geographic boundary line, someone is always on the wrong side.

If Iowa and Nebraska are not in the same region, to pick an example from your State, Senator Grassley, then the Iowa people are not going to be able, some of them in the western part of the State, to slip across the Missouri River into Omaha, which is a major medical center.

Similarly, you could just imagine what could happen around New York or Washington. There are dozens of areas in the country where boundaries could create big problems. We have a lot of experience with those problems and there are no solutions to them except to avoid constraining the plans. As another example, exempt these plans from State mandates.

Finally, and this is really my main message here, do not let the budget constraints ruin your program design. Keep it clean and simple. It will evolve over time, but let it evolve over time. Make sure the program does not fail from day one. Thank you very much. Those are my prepared comments.

The CHAIRMAN. Thank you, Mr. Francis.

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

The CHAIRMAN. Now, Ms. Moon?

**STATEMENT OF MARILYN MOON, SENIOR FELLOW—HEALTH POLICY CENTER, URBAN INSTITUTE, WASHINGTON, DC**

Ms. MOON. Thank you, Mr. Chairman, Mr. Baucus, and other members of the committee. I am very glad to be here today.

I would like to start out on a very positive note. I am glad to see some important improvements in this package over some of the earlier proposals that have been discussed.

The equal drug benefit between traditional Medicare and the PPO offering, is extremely important, although I have some caveats that I will mention in a few moments.

Second, I am very glad to see the generous coverage for those with low incomes. People with low incomes need substantial benefits because they are, after all, folks who have very little income with which to pay for drug costs. And the costs of even a 2.5 percent co-pay, if you are spending \$4,000 or \$5,000 a year, mounts up very quickly.

It is very important that those benefits are comprehensive and that asset tests, for example, are minimized in this program. But there are many issues that remain that could be improved within this framework, although some of them would be very challenging to do.

First, it is important to improve low-income protections beyond what is here. There should not be even the perception that dual eligibles, that is, people who get both Medicare and traditional Medicaid, the full Medicaid package, are not part of Medicare.

To have them be given drug benefits, for example, exclusively through the Medicaid program, is a problem because it sets up the perception that they are second-class citizens and not part of the universal coverage that Medicare provides. These folks should be at the head of the line, not at the back of the line.

Second, it is important to expand protections to people above 150 percent of poverty. Those folks still have modest incomes and can pay a large share of their incomes on prescription medication.

Let me mention the table that people have talked about and say a couple of things about it. First of all, the calculation includes premiums, and that is how you can end up paying more than you get from the program.

Second, the example of a person at 175 percent of poverty was meant to illustrate that at \$4,000 of total spending, the individual would pay \$2,833, which would amount to 17 percent of that person's income. This leaves a substantial burden on those individuals even after accounting for new benefit.

I understand about the problems of budget constraints, but this is just an example of the penalty it leaves on individuals when the protections do not rise high enough up the income scale.

The drug benefit also needs improvement for the across-the-board plan as well. A \$400 billion limit causes a lot of problems. The main one is the donut hole that people talk about, or the big gap that exists in this program.

This gap represents policy driven not by good ideas, but by the dollars that are available. I do not know any analyst who would say a gap is a good idea. It gets a lot of legitimate criticism.

Someone with \$5,000 in expenditures gets the minimum amount of protection once you get a little bit above the deductible. That person will only have about 31 percent of her expenditures protected as compared to a higher percentage for someone who is spending \$1,000 or \$2,000, for example. That is simply not good policy.

It would be better to have a lower, flat percentage if you are going to have minimal amounts of money to spend than to penalize people who spend in the range of \$3,000, to \$5,000, to \$6,000, which is the level of spending for the chronically ill who are taking medications every day for the rest of their lives. And it is not just a case of high spending for 1 year. These people will have those expenses every year for the rest of their lives.

Also, I have some concerns about the stand-alone drug plan and whether or not it will turn out to be a valuable plan for beneficiaries. I totally agree with Mr. Scully when he said that what he would really like to have is a drug plan that would be integrated with the rest of the benefits. It makes it a lot easier to run, it makes it probably more efficient, and therefore the individuals will get more.

But the problem is, the stand-alone plan is aimed only at traditional Medicare enrollees, putting them at a disadvantage compared to those who choose private plans. Further, if the fall-back protection comes in and out, as people have already discussed, the plan will be even worse.

I see my time is about to run out, so I will simply mention a couple of additional points and hope that someone will ask me about them.

We should not over-sell PPOs. PPOs have a place. They do some good things. But they are particularly a problem for low- and moderate-income seniors because of the out-of-network benefits.



It is not true that everyone in PPOs has access to all hospitals and doctors, because if you have to go out of network, I can do it, I can pay the 70 percent co-pay that effectively I face, but many seniors will not be able to do so. Therefore, it has been over-sold as full access.

It puts people in the dilemma then of having to decide whether they will have to change their physicians, in many cases, in order to get the other benefits, and that is a choice that beneficiaries should not be asked to make.

There is also very little utilization control in PPOs. The main way in which they do it these days is to toss doctors off the program if they do not like the fact that the doctor is ordering too many tests, et cetera. This is not exactly what I think of as ideal control.

Finally, I would say, improve the basic Medicare program. If these ideas of stop-loss and chronic care coordination are good ideas, and I believe they are, we should work hard to get them into the basic Medicare program as well because that is where the majority of seniors will be, by everyone's admission, for as long as possible.

Level the playing field. Do not pay more to private plans. Let them prove themselves in the marketplace, which is what, presumably, they are asking to do.

Thank you.

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

The CHAIRMAN. Ms. Moon and Mr. Francis, let me thank you both in advance for your testimony.

I want to thank Senator Baucus, because when I am done asking my questions, he has agreed to finish the meeting for me so I can be at a Waterloo, Iowa Economic Development Task Force meeting in the morning and I will have to leave fairly shortly. But it is very important to have the different points of view that you have expressed.

I am going to start with Mr. Francis and ask about the steps that the Federal health benefit plans take to protect patients' rights, particularly access to specialists, to women's health care, emergency services. It seems to me like many critics of PPOs and Medicare say that seniors will be kind of thrown to the wolves, and with these new options, that that will not be a concern.

But, in fact, FEHBP, which we are modeling our program after, has some of the strongest patient protections, or at least that is what I believe. Senator Baucus and I intend to replicate those wherever we can.

So I would like you, Mr. Francis, if you would, to expound on a few of those key protections to emphasize the protection that patients have, or at least as I see it.

Mr. FRANCIS. Yes, sir. First, built into the program are two things that are just huge protections. Number one, let us be clear. There are 12 plans that are national in scope that serve every hamlet, every rural area, every city in the country.

In all those plans, you can go to any doctor in the country who is accepting patients, period, and pay the fee-for-service component. You will pay out of pocket.

It is typically 25 or 30 percent, assuming your doctor charges a reasonably low fee. It can be higher. I think Marilyn's experience has been a little unusual. So you always can go to see any doctor you want, period. That is point A. If he exists, you can see him.

Point B, if you do not like your plan's selection of preferred providers, you can change plans each year in the open season. So that is your second major protection.

Third, we have built into the program all kinds of quality controls and appeals rights, the details of which I will not bore you with. But it turns out, half of the OPM staff who administer this program do nothing but hear final appeals to coverage disputes, for example, though normally, the plans resolve these.

There is just a huge level of satisfaction, so there is not a problem that anyone can point their finger at that suggests that people, in any consequential numbers, are having coverage or access problems. Obviously, the networks are not equally thick everywhere on the ground.

One of the other important protections is multiple plans. One concern I have with what I am hearing about this as yet unrevealed proposal, is there may be only three plans per region.

I think that could be a mistake. Sometimes it takes that full dozen plans for a Federal employee in a rural area to get just the preferred provider panel he needs. But those are the main protections, sir.

The CHAIRMAN. Thank you. Another point to you is to make sure that we are not throwing people that might go into the new plan to the wolves, and as we have tried to replicate maybe some experience in the Federal program, and the role of the Office of Personnel Management to referee those, to discuss that, because obviously we are going to make sure that we have similar protections for our seniors.

What does an employee do if there is a dispute with a plan in which he or she is enrolled? Can they appeal to OPM, and how critical is this function in the working of the Federal Employees Health Benefit Program?

Mr. FRANCIS. Obviously, these issues arise from time to time. All the contracts say the plans must pay for all medically reasonable services. So you are starting with, if you go to a doctor and you think you need a particular service that doctor provides, you are extremely likely to prevail just automatically, just because no one is even going to question it.

Obviously, there are exceptions, such as cosmetic surgery, unless you were disfigured in an accident or something. But, basically, medically necessary care, you are going to get. If you do not get it to your satisfaction, you can appeal within the plan.

OPM requires the plans to hear those appeals, to let you go to several levels within the plan if you do not like the first answer you heard, and if necessary, you could appeal to OPM. It is a process that seems to work extremely well.

I have counseled a lot of people, hundreds, thousands of people in this program, and I have just never heard a complaint about being unable to get needed care. I have heard complaints about, gee, I wish the plan covered something that it does not cover, but that is a different issue. Typically, it is not a medically necessary

kind of service. So it works very well. The proof of the pudding is in the eating, in this case.

The CHAIRMAN. Dr. Moon, you point out that Medicare has a better track record than private insurance in controlling growth of costs. But it seems that you admit that the Federal Employee plan, and CALPERS as another example, have had better success in controlling costs. Mr. Francis seems to have made the same point.

Given that the reforms we are considering are closer to Federal Employee, CALPERS, and other private insurance, is that not a more appropriate comparison, and not over just the last five or 6 years, which have been Medicare's best, but over a longer period of time, like 10 to 20 years?

Ms. MOON. My sense of the comparison with CALPERS and FEHBP is that they have done a little bit better than the private sector, not necessarily that they have done better than Medicare. The differences are hard to sort out.

But my concern is that many people often start with the assumption that the private sector will instantly solve all of the problems of Medicare and lower costs over what Medicare's costs are, and I do not see any evidence of that.

In fact, I often point out when I talk about this that these programs do track each other. Medicare adjusts and makes changes over time when it gets out of synch with the private market, and so forth. But I think it is important to stress that Medicare is not a problem in terms of having been out of control in terms of its growth.

The comparisons we did across the board controlled for prescription drug prices, for example. And when we looked at PPOs recently, we learned that the deductibles in PPOs are rising very rapidly, as are the premiums that employers have individuals pay.

They have gone up by more than twice as much as the premiums for Medicare, for example, since 1988. Again, that is not FEHBP. But I think the point is, it is not the case that Medicare is a terribly troubled program and doing much worse than the private sector.

The CHAIRMAN. And I have one further question that I am going to submit for answer in writing to you, Dr. Moon.

Ms. MOON. All right.

The CHAIRMAN. Thank you, Senator Baucus.

[The question appears in the appendix.]

Senator BAUCUS. Thank you, Mr. Chairman.

Ms. Moon, several people have pointed out, I think quite a legitimate concern, namely, seniors, because it is a 1-year contract period, will be, perhaps, very confused. That is, a private plan may be in in a year or two, or out, and fall back. Just, what is next?

Ms. MOON. Yes.

Senator BAUCUS. That problem. It is a concern I have, too. Given the basic framework of what we are talking about here, I am just curious what suggestions you might have as to how to address that, and your comments on Mr. Scully's response to Senator Lincoln's concern in that regard. He mentioned right off the top, as soon as she completed her question, that actually he thought that this would be less confusing to seniors.

A, it is a problem. B, what ideas do you have, or where do we begin to try to minimize some of the confusion that might occur? I do not know it is going to occur. It may be that there are some areas of the country that there are no plans, so it is always the fall-back. Still, I think it is a very legitimate concern.

Ms. MOON. Well, I think a couple of things, right off the bat, could help. One would be a longer period of time in which prescription drug plans make a commitment to stay in the market and then you might allow additional ones to come in and let people voluntarily change if they wanted to if the prices were lower. But people should be able to stick with a plan that they find attractive.

Another would be to have a fall-back available to people in all cases. In that case, the government might experiment with using medical information to try to provide a more limited drug benefit, that for example covers only drugs that have shown to be effective and appropriate. These decisions need to come from a source that is objective. You are not going to see this approach coming from formularies designed by PBMs.

The best way that PBMs have to save money, is to use a formulary that is very restrictive because then they can go to the prescription drug company and say, what price will you give us if we promise to send everybody to you to get their anti-cholesterol medication?

The real problem causing confusion is that presumably Express Scripts will get something different than Advance PCS in their deals. So if you have to change plans from year to year, you may have to switch drugs. We know in many cases that is not a good thing for people to do.

Both the side effects that arise from drugs can be considerable in many cases, and it is also confusing to patients to tell them that, yes, we told you Lipitor was the very best thing to take last year, but now it is Pravachol that is the very best thing to take. I know myself, when I take numerous medications, I keep track by the color, size, and all of that. I think it is no different for seniors.

Senator BAUCUS. So one would be to allow more seniors to have more options and to be able to choose so they are not locked in. Also, to maybe provide for a fall-back for a greater period of time.

Ms. MOON. I think the fall-back needs to be there longer, if not all the time. Certainly once a fall-back is triggered, it should stay in place for a number of years. That is also a way to test whether or not the government can do a better job at offering prescription drug benefits than the private sector. I am not sure which consumers will prefer. If the Federal Government did a good job and took a slightly different tack and said, let us do it on the basis of good medical information, not just who is offering the best possible price at that moment.

Senator BAUCUS. What do you think about that, Mr. Francis? What if the fall-back were there for a longer period of time?

Mr. FRANCIS. I cannot think of a greater political disaster for this country than to have the Congress of the United States decide. Because that is who will decide, not some expert panel. The expert panel is going to say Lipitor is better than Pravachol, or vice versa.

The fact is, one of them is better for some people, the other is better for others, and you often have to try them to find which one

is better for you. I have had to switch my medication for cholesterol, actually, between those and yet another one.

The notion that there exists some Oracle at Delphi in the government who can pick the best pills and then the losing drug company and clients that want that pill paid for are not going to come to the Congress to complain, I just cannot see that.

You know the experience you have in adjusting Medicare payment levels because of the differences between urban and rural levels and so on, and you are always tinkering with those boundaries and those differential levels. It just would be a nightmare.

The whole advantage of the Federal Employees Health Benefit Program is it takes all of those decisions out of the political process. If I am a Federal employee and a plan I am in this year decides to have a formulary next year that is going to leave out Lipitor, I can change plans. By the way, they never leave one out, because they would lose too many customers.

They are trying to keep customers, not lose them. The worst they are going to do to me, is say, well, we have some preferred drugs, and so for the preferred ones you will have to pay \$20 a prescription instead of the regular \$10 that we otherwise would charge you. That is how they handle those kinds of issues. No muss, no fuss, no controversy.

Senator BAUCUS. I appreciate that. My time is expired. If you could just, for 15 seconds, maybe, how do we minimize the potential confusion that I addressed to Ms. Moon?

Mr. FRANCIS. There is an awful lot of confusion, including, as Tom Scully mentioned, just within the traditional Medicare program. It confuses people in all kinds of ways.

Some author recently, a health researcher, said he did not realize until he turned 65 that he was not even eligible for Medicare because he had been in State-exempt employment. There are just all kinds of levels of confusion, and you are never going to prevent them totally.

One of the nice things about the FEHBP as a program, is people tend to stay with the same plan. I think it is very important, the stability aspect that Marilyn was emphasizing.

If you can stay in the same plan and with the same providers over a period of time, this greatly helps. That is the reality of the program. Even though people do have this open season and it puts pressure on the plans, most people wind up in a very comfortable groove.

Senator BAUCUS. Senator Bingaman?

Senator BINGAMAN. Thank you, both, for being here.

Let me just indicate a concern that I have got. We are talking about enacting a bill that will cost \$400 billion over 10 years and where there will be a requirement that people pay premiums to get this prescription drug benefit.

But for this group, which are relatively low-income and also chronically ill, and I think, Ms. Moon, you referred to these folks, for example, you take a couple with an income of \$21,200 annually and that same couple has \$6,000 worth of drug costs during the year, that is chronically ill, we are essentially saying that the government, through this program, is going to pick up about 30 percent of the cost.

That does not seem to be an adequate prescription drug benefit for this group. I do not know. It may be adequate for a much higher income group, but for that group it seems we ought to be able to do better than that. That is 175 percent of poverty. It just does not seem to me we are doing what we ought to be doing.

Is that your basic view, Ms. Moon?

Ms. MOON. Yes. As I indicated, I think people between 150 and 200 percent of poverty are particularly vulnerable in this plan, and the gap creates problems for folks who have chronic conditions.

There are ways in which you could tinker even within the budget numbers you are talking about, but \$400 billion is a limit that makes it very difficult to find the magic bullet.

I have looked and it is very hard to find a way to improve the benefit structure, in part because \$400 billion, which is a lot of money, is only 25 percent of what people will spend who are Medicare beneficiaries over the 8 years starting in 2006.

Senator BINGAMAN. I guess if I were chronically ill and had a substantial prescription drug bill each year, I would probably, even if this proposal becomes law, be anxious to go out and buy some kind of Medigap coverage to cover the rest, or do something.

I mean, if this plan is going to cover 30 percent of my \$6,000 prescription drug bill each year, then I would probably want to see if I could not get someone else to help me with some of the rest of it.

As I understand it, this proposal is going to repeal the legislation that provides for Medigap plans. That seems unwise to me. We ought to be permitting the existence of Medigap plans, even if this becomes law. Is that a crazy idea, either one of you?

Mr. FRANCIS. I will take a shot. I think the concern you are raising is extraordinarily important, Senator. I agree very much with Marilyn. The danger here is, you have got to strike, with a very tight budget total, a right balance.

You want the drug benefit to be generous enough so that people will find it basically meets their needs for drugs. Again, it is a matter of details and I do not know them anyway, but we may need to charge a higher premium, and give a higher subsidy to the poorer groups.

There are adjustments you could make, trade-offs you can make. You do not want to wind up in a situation where people have to buy a supplemental plan because the one they are getting from the government is so lousy.

That is the situation, of course, people are in now. Ninety percent plus of all Medicare recipients have some form of supplemental coverage, either from a former employer, or through Medigap, or through Medicaid.

That whole system can be greatly improved. Indeed, one of my concerns is, I do not want to let the employers fully off the hook, either. They have a lot of money. They have skin in this game already. You would like somehow to recoup more of that money, and your design details can make a difference on that point. So, that is part of the answer, but I will defer to Marilyn on more details.

Ms. MOON. The issue of Medigap is a complicated one. Medigap is not a good deal now for anyone to buy prescription drug coverage because of the risk selection that occurs.

In fact, if you were counseling any of your relatives, tell them to buy the cheapest Medigap plan that covers the least, because it will not have the problem of risk selection.

But the issue of filling in the gaps is a really tough one because it is my understanding that there are two different ways in which people have talked about these plans. I do not know what way this bill goes.

One, is what people call true out-of-pocket and the other is regular out-of-pocket. As I understand it, true out-of-pocket means that only what you actually pay will count towards getting you to, for example, the stop loss.

If that is the case, then the message that you send to both individuals and to employers is that every dollar that is contributed from some other source goes to reducing what the government pays, not what consumers would have to pay.

If it is the regular out-of-pocket that most of us think about, as long as you can demonstrate someone has paid \$4,000 on your behalf, then you get the extra benefits. That allows extra supplemental coverage. But it makes a big difference in terms of what the cost scores are, as I understand, as well.

Senator BINGAMAN. All right. Thank you very much. Thank you.

Senator BAUCUS. Thank you, Senator.

Senator SNOWE?

Senator SNOWE. Mr. Francis, I wanted to refer to something that you mentioned earlier with respect to the Public Citizen report, and I would like to have your response to the report. You mentioned Gardiner. Did you mention Gardiner?

Mr. FRANCIS. Yes, ma'am.

Senator SNOWE. That is not in Franklin County, it is in Kennebec County.

Mr. FRANCIS. Then I may have written this down wrong. But I pulled a zip code from Franklin County.

[For the record, I used Farmington, zip code 04938.]

Senator SNOWE. All right. I just wanted to clarify that. That is what I thought you said, and Gardiner is in another county.

So I would like to have you respond to some of those issues concerning PPOs, because obviously the essence of this report is that many of the providers who currently participate in the Medicare program are not part of a PPO network. Obviously, that is an issue for rural areas.

You have mentioned the fact that you believe that the Federal Employees Health Benefit Plan is a model on which to predicate providing access in rural areas. It is my understanding, for example, Blue Cross and Blue Shield, said today they had an option of not participating in a national plan, and they would not because it is too complicated and too onerous. So how would you address this issue in making this an attractive option in rural communities?

Mr. FRANCIS. There are a couple of things. First, it is important to have a multiplicity of plan, because Plan A may have a good provider network in your community and Plan B does not. So, you would like people to have an ability to get into a plan that has good preferred providers that they want to use, so multiplicity of plans helps.

Stability helps. We sure do not want to recreate the errors of the Medicare+Choice program, which we do not need to dwell on here, but these are lessons we have learned, I hope.

Again, I do not know the details of what you are proposing. In the FEHBP, it is extremely important you always have the safety valve of the fee-for-service. While I am in Blue Cross I am normally crazy not to use a preferred provider because I get such a cheap physician visit.

Sometimes you really want to use a particular physician and he is not preferred. You can go and talk to that physician. You can usually make sure you are not charged an outlandish rate, and then the plan will pay 75 percent of that cost.

It is not perfect. It does not solve every problem. I mean, there are no universal, 100 percent, I-can-guarantee-everybody-everything-they-need ways to approach this. The point I think here, is that we have a real, live, in-action model that says people have a multiple set of plans to choose from, and by golly, in the rural counties of America it works. There was another study done by an outfit called RUPRI, Rural Public Policy Research Institute, or something like that, where they actually counted the number of Federal employees and annuitants, who are about a third of the total here, who signed up for how many health plans in every county in America. They found that only 2 percent of the rural counties had fewer than two different health plans signed up for it.

In most of these counties, and these are the rural counties all over, five, six, or seven different plans were being signed up for by Federal employees and retirees.

Well, people are not signing up for plans without good provider networks. I mean, they are not stupid. They learn these things. So what we can observe, and there are a lot of ways to try to measure all this, is ready access to rural areas.

I would just say, Public Citizen simply bombed out and did not do it right. We are observing a reality here, which is that Federal annuitants—Senator Rockefeller earlier said he has not heard constituents say much about the FEHBP. He made this a disparaging comment.

But I took it in a different way, Senator. I thought, gee, I think maybe you are not hearing a lot of complaints about this program, because you would have mentioned those if you would have heard them. The fact that we do not hear complaints about coverage from rural areas, I think, is extremely important.

Recently here in D.C. there was this big issue over the Care First plan not paying for Children's Hospital, and it blew up and was front-page news, and all that. Well, those are very rare problems in this program. You would be hearing from your constituents if they were not rare.

Senator SNOWE. And you think that it is important to preserve the traditional fee-for-service program?

Mr. FRANCIS. Absolutely. I guess sometimes you get to talking about your specific points. The starting point in all this is, we have a working, functioning program which is a financial lifeline to 40 million Americans.

Well, they do not all have to have it, but the majority of them certainly do. We do not want to jeopardize that structure. The



question is, can we not build something better and let people voluntarily, over time, move into that structure and let it evolve over time?

Senator SNOWE. Ms. Moon, obviously you do not agree with Mr. Francis with respect to providing an option with a PPO.

Ms. MOON. I do not have a problem if you want to provide an option with a PPO. But I think the important thing is that the PPO should not be given extra money to make it look better than Medicare just because you are subsidizing it.

There are a number of protections that would be needed. I also think that the PPOs have been over-sold in terms of how well they can work, in some cases. The program does need to have options for people who want to move out of traditional Medicare, but I want to see the traditional Medicare program preserved and strengthened as well.

Senator SNOWE. Thank you.

Senator BAUCUS. Thank you, Senator.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Just continuing on that, Marilyn.

Ms. MOON. All right.

Senator ROCKEFELLER. I am worried about seniors who are going to be paying premiums for many months and getting no drug coverage at all. It is what we call the donut. It requires seniors to pay over \$1,000 out of pocket on their prescriptions before they receive any benefit.

My question is, even though we do not really have a full plan that we will be voting on, do you have some sense in rough terms of what percentage of seniors will end up in this donut, and also what percentage of seniors will pay more benefit than they receive?

Ms. MOON. I have not looked at who would pay more benefit than they received. But if you look at the distribution of spending—and my projections only go out to 2005 about a quarter of all beneficiaries would be in the range where they would be affected by the donut.

This includes not only the people whose spending is in that range and never get out of it, but also the folks with higher expenses because they are affected as well. If you have to pay 100 percent of your costs for a while, even if eventually qualify for further protection, you still would have had that period in which you paid 100 percent of the costs.

Senator ROCKEFELLER. About 25 percent.

Ms. MOON. Yes, about 25 percent.

Senator ROCKEFELLER. As I indicated when I gave my cheerful opening statement that I am very concerned that West Virginians have equal benefits to all of the seniors across the country, I am disturbed, obviously, then that what we are going to be considering and voting on next week, if PPOs receive a higher benefit, which I indicated—well, I called it bribery—equals the entire amount we gave to all the States in fiscal relief, or perhaps \$5 billion more than that, does that mean there will be an unequal benefit in the PPO option as compared to the traditional Medicare that there could be?

Ms. MOON. I assume that is what it would lead to, or else higher profits for the PPOs, or else in a less efficient system.

Senator ROCKEFELLER. And is it also true, just so I can get my questions in, that this plan, to the extent that any of us understand it, that the PPOs can use that extra money for whatever they want and that therefore they can obviously use that to produce a better benefit?

Ms. MOON. Well, like you, Senator, I have only seen a two-page summary, so I do not know what that means.

Senator ROCKEFELLER. But that is a possibility, is it not?

Ms. MOON. It is a possibility.

Senator ROCKEFELLER. If my supposition is correct that there are no restrictions on how they can use that money.

Ms. MOON. I assume that is a possibility, yes.

Senator ROCKEFELLER. Yes.

Another fundamental problem, is there a national premium. I do not think there is. That means if there is no guarantee that West Virginians will pay the same premium as seniors in California and New York, I am going to be very angry and very disturbed. I think it is a major problem, as I understand the structure and the two or three pages that we are dealing with.

So how do I explain to seniors in my State that, because very few private plans will want to come to West Virginia, and none exist there now, that they will have to pay a higher premium than people in other States? Why should I explain that to them as being in their interests? How can I?

Ms. MOON. The problems of geography are always problems in Medicare reform. When you make it very visible by allowing things like premiums to vary, you will have a lot of unhappy beneficiaries. Legitimately, they will ask why they should pay more.

It is also likely to be the case that in some places where people would expect they would have low premiums, because there are multiple plans, that they will still be high and expensive because there is some variation in use as well. One would hope that they would be low in West Virginia, but I think you have no assurance of that.

Senator ROCKEFELLER. And so, Marilyn, once again, I call upon your expertise. Is it your understanding that, under this proposal, there can be national variation in premiums?

Ms. MOON. That is my understanding.

Senator ROCKEFELLER. Variation is not precluded from happening.

Ms. MOON. My understanding is that plans would be given a subsidy, but they would be allowed to charge the premiums that they think they need to offer benefits.

Senator ROCKEFELLER. And if that is the answer then, what does that mean for rural beneficiaries like the folks in my State? What are they likely to lose in terms of benefits and cost?

Ms. MOON. I think that it is very difficult to know, because it would depend upon how the subsidies that go to the plans vary by geography and vary by the risk and problems that people have who will be purchasing those plans.

The difficulty of adjusting what you are going to pay for a prescription drug subsidy, depending upon whether you are talking

about an 85-year-old lady with four chronic conditions versus a 70-year-old lady who is running marathons, has eluded many researchers for a long time. So, I think it is going to be a problem.

Senator ROCKEFELLER. Thank you.

Senator BAUCUS. I thank everybody. What struck me in this hearing, I think it has been a very, very good one. There have been a lot of good questions asked and a lot of good answers. Slightly different points of view, but not dramatically. It is part of, without being too corny, the American process. It is the legislative process here.

I thank you all for participating. You have been very, very helpful, and particularly, I think, the good questions asked by various Senators. This is just one step of many that we will be undertaking to try to find the best way to get a prescription drug for seniors.

I just want to thank you all so very much for being part of it. I am quite certain that there will be many further discussions among us and others as we proceed. Thank you very much.

The hearing is adjourned.

[Whereupon, at 12:47 p.m. the hearing was concluded.]



## APPENDIX

### ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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#### PREPARED STATEMENT OF HON. MAX BAUCUS

Thank you very much, Mr. Chairman. As always, I appreciate your leadership of this Committee, and your willingness to work with me. I would also like to thank others on the Committee for their longstanding work on Medicare. In particular, I want to thank Senators Breaux, Snowe, Hatch, and Jeffords for their work over the years.

Some may take issue with the speed of our deliberations. While I do not agree with them in all respects, I will say this: I firmly believe that we should not proceed until we have a cost estimate of the plan from the Congressional Budget Office. And if we do not have those numbers, I will urge the Chairman not to proceed.

But we are at an important point. Sometimes, there comes a time when you have to fish or cut bait. We have \$400 billion on the table, specifically earmarked for Medicare reform and a prescription drug benefit. We have been at this point before and let it pass us by.

Yes, it would be nice to have more funds available for this policy. And yes, a richer benefit would be more desirable. But the question is: Will we let the opportunity to use these funds pass us by again? I don't think so. This time, it's going to be different. This year, I believe the stars are aligned. Chairman Grassley and I have put together a solid framework that I believe will help seniors across the country.

It's not a perfect package. Nothing ever is. Sure, there are provisions that I would have liked to see in the bill. And others I might not have included. But I think it's a good bill. A good start toward helping seniors get the prescription drug coverage they need. And getting everything you want is not what Congress is about. None of us can pass a bill by ourselves. The bill we will pass will be a product of many different opinions and many different points of view. Too often lately, it feels as though people don't even want to try to work together. But by not working together, the only people we'd be hurting would be the ones we were elected to serve.

The framework that Senator Grassley and I outlined publicly yesterday would establish a voluntary drug benefit under a new Part D of Medicare. If a senior decides to join a private managed care or preferred provider plan, then the prescription drug benefit would be rolled into that plan. If a senior decides to stay in traditional fee-for-service Medicare then the senior would receive drug benefits through a stand-alone plan. But the value of, and subsidy toward, the prescription drug benefit would be equal for seniors who move into private plans or who stay in fee-for-service.

Unlike the President's plan, this proposal does not force seniors—90 percent of whom are in traditional Medicare—into a private plan that they neither want or need. This is especially important to rural states like Montana, where most seniors don't have the option of moving into a private plan, because those plans don't exist.

That leads me to my next point. Under our proposal, Chairman Grassley and I have included a strong government fallback. Seniors must have access to at least TWO private plans for a prescription drug benefit, or the government will provide a fallback plan. If there is not true competition, then traditional Medicare would provide a fallback.

We've also focused on making sure the drug program is accessible and affordable for our low income seniors. Low-income seniors would pay no more than minimal cost sharing at all levels of spending. We have done much to eliminate what people call the "donut" of high copayments for low income seniors.

I have a good feeling about the progress we've made. We're on the right track. The proposal Chairman Grassley and I are working on is still very much dependent

on the CBO score, which we expect to receive Sunday. I anticipate that changes may need to be made, but we're in a good position.

I'd like to thank Chairman Grassley for seizing this opportunity to work together. And I'd like to extend an invitation to all of my Finance Committee colleagues. I ask them to join us and work together to develop this Medicare prescription drug bill.

I believe that it's time to take advantage of the opportunity that's available to us and pass a good bill. It's time to help our seniors.

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PREPARED STATEMENT OF HON. JIM BUNNING

The Medicare bill will be the most important bill Congress considers this year. Seniors have waited too long for this benefit, and we have a responsibility to our constituents to pass a bill this year.

We have \$400 billion set aside, and we should create the best benefit possible with that money.

I am particularly concerned about the benefit we provide to low-income seniors. These are the people under 135% to 150% of poverty.

These are the people who really struggle to afford their drugs, and these are the people we should be most concerned about helping.

One hundred percent of poverty means that an individual's income is about \$8,980, and a couple's income is \$12,120. At 135%, an individual makes about \$12,123 and a couple makes about \$16,362.

These aren't rich people by any stretch of the imagination.

Personally, I don't see a reason why rich seniors like Warren Buffett—or many of us sitting around this table—should get a drug benefit at all.

I also think it is very important for low-income seniors to receive good assistance between the time when Congress passes this bill and when the program can be implemented in 2006.

I feel very strongly that we should provide as much of a subsidy as possible to low-income seniors during those first two years. I believe that \$600 a year for two years is a good start in that direction.

The amount of money for a low-income subsidy is minuscule compared to the overall costs of prescription drugs, and it is the right thing to do.

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PREPARED STATEMENT OF WALTON FRANCIS

In my dual careers and capacities as a consumer advocate and advisor on how to choose the best health insurance plan,<sup>1</sup> and policy analyst advising on government policy options and reforms, I have long argued that the FEHBP is a highly promising model for Medicare reform. This testimony addresses the myths and realities of that comparison. It is based on, and expands, testimony I provided to the Special Committee on Aging of the United States Senate on May 6, 2003.<sup>2</sup> I address specifically some of the design issues facing this Committee as it prepares a bill for submission to the Senate.

A careful student of both the FEHBP and Medicare programs opened several years ago that "the FEHBP has outperformed Medicare every which way—in containment of costs both to consumers and the government, in benefit and product innovation and modernization, and in consumer satisfaction."<sup>3</sup> I agree. In this testimony I provide data that will support these conclusions and also dispel misconceptions about the FEHBP.

Careful analysis of these issues is particularly important because in recent years there has been a steady growth in misrepresentation of the FEHBP's performance, directly or by implication, from defenders of the statist Medicare model. For example, a recent analysis is described in its abstract as an answer to those who "seek to remake the federal health insurance program for the elderly . . . on the model of the . . . Federal Employees Health Benefits Program. This paper . . . rebuts those arguments by showing that Medicare beneficiaries are more satisfied with, have better access to, and have greater confidence about their access to health care, and they report having fewer financial problems as a result of medical bills" than those enrolled in private employer plans.<sup>4</sup> The body of the analysis, and the survey data themselves (discussed below) do not support the claims in the Abstract. Another analysis says that "FEHBP has done . . . slightly worse than Medicare, on average, [in controlling costs] since 1996."<sup>5</sup> The selection of 1996 as a base year leads to a conclusion contradicting the author's own analysis in a prior report showing that the FEHBP outperformed Medicare very substantially from 1992 to 1997.<sup>6</sup>

This same author persistently states that there are only 6 plans available to all Federal employees and retirees when there are in fact 12 plans available to all, and 15 to 20 available to most?<sup>7</sup>

*Benefits.* Medicare serves as a lifeline to the elderly of America. Its coverage of hospital and doctor costs is vital to the economic well being and survival of millions. Yet, Medicare is infamous for its obsolete, vintage 1960 design. It does not provide a catastrophic ceiling on costs even for those costs it covers. It does not cover prescription drugs (except in rare instances). It does not cover many preventive services. It does not cover dental services. By failing to cover health care costs incurred abroad (except in Canada and Mexico), it forces the elderly either to forgo retirement travel outside of North America or to obtain other coverage. Indeed, so deficient is Medicare coverage that over ninety percent of its enrollees purchase supplementary insurance, or have it purchased for them.<sup>8</sup>

None of these deficiencies affect the FEHBP. That program was also created vintage 1960, but it has painlessly evolved over time through the competitive, consumer-driven process that is its central feature. The Medicare plan can be rated for its benefit coverage in 2003, compared to average FEHBP plans. For a retired person without dual coverage I obtain the following results (these data include dental costs and exclude premiums) using the methodology of *CHECKBOOK's Guide to Health Plans for Federal employees*:

Category	Medicare	FEHBP
Average Out of Pocket Cost	\$2,640	\$1,260

Likely Cost at Expense Level of \$84,000	\$12,580	\$6,080
Ceiling on Combined Hospital, Doctor, and Drug costs	None	\$5,000 plus or minus \$1,000

These cost comparisons demonstrate that **FEHBP retirement benefit coverage is far superior to Medicare's.**

There is another significant dimension of benefit superiority. In both programs the great majority of common hospital and physician procedures are covered routinely. However, at the margin Medicare coverage choices are dictated either by statutory law or by administrative law dictated through the Medicare coverage processes. Although there is some variation by area because of carrier discretion, this tends to be minimal. Further, all Medicare HMOs are required to offer benefit coverage identical to that in traditional Medicare. In the FEHBP, in contrast, coverage choices are made by individual plans. This means that consumers can seek out plans that have better coverage for particular services of importance to them. Acupuncture, cardiac rehabilitation, expensive dental procedures, and other services are usually available, at a price, in some available plan. Medically proven procedures, such as pancreas-only transplants, and the latest advances in pacemakers, are covered in all or almost all FEHBP plans, but are often covered by Medicare only after years of delay, if ever. And FEHBP plans are free to, and often do, cover services that they would not ordinarily cover at all if these are approved as part of a case management package tailored to a particular enrollee's needs.

**FEHBP benefits have improved markedly over time.** During the ten year period ending in 1992, out-of-pocket costs in the FEHBP for a market basket of hospital, medical, drug, and dental costs decreased from about 32 percent of total per enrollee costs to about 20 percent of total costs.<sup>9</sup> This improvement resulted from benefit improvements in both fee-for-service and HMO plans, and from a significant shift in enrollment from the former (higher cost) to the latter (lower cost). Both sources of improvement have largely halted in the last decade, primarily because of rising prescription drug costs and increases in copayments aimed at restraining

these. Furthermore, copayments play a significant role in restraining FEHBP costs, and plans have very little room left for copayment reduction without facing untenable cost and premium increases. Finally, as plans approach complete coverage, the margin for further improvements necessarily decreases. However, no such improvement has ever occurred in Medicare, whose benefits have, on a market basket basis, deteriorated over this entire period.

*Provider Choice and Access.* Medicare is, in a sense, one of the relatively few remaining fee-for-service (FFS) medical plans in America. Most private plans either limit provider choices substantially or, as is quite common, provide differential cost sharing depending on whether or not the provider is “preferred”. Of course, Medicare is not really fee-for-service since it regulates prices and, indeed, makes it illegal for providers to negotiate higher prices with enrollees and still obtain any reimbursement.<sup>10</sup> The FEHBP national plans almost all allow enrollees to go “out of plan” and pay only one fourth of a reasonable charge above that level. These plans’ reimbursements are more favorable for “preferred” physicians, but some payment is available whether the physician has any arrangement of any kind with the insurance company. At worst, the patient pays the bill and then gets reimbursed directly from the insurance company. **Every Federal retiree can join a dozen health plans that reimburse him for most of his costs for virtually any physician who accepts private patients at all. More physicians are available through the FEHBP than through Medicare.**

The Medicare Payment Advisory Commission conducts surveys of physicians and in its most recent report found that physicians are significantly less willing to accept Medicare patients than private plan patients.<sup>11</sup> Specifically, in 2002 over 99 percent of physicians accepted private FFS and PPO patients, but only 96 percent accepted Medicare patients. This is a seemingly small difference but if it is your doctor, or the best specialist in town, who will not accept you, it can have a major effect on your health care. And until recently enacted payment increases, it appeared that the proportion of physicians unwilling to accept Medicare patients was about to rise substantially.

In this context, the FEHBP has a significant advantage over Medicare because of its multiplicity of plans. **Every Federal employee or retiree, no matter where he or she lives, anywhere in America or anywhere in the world, has no fewer than twelve plan options from which to choose in 2003.** (This includes both “high” and “standard” options offered by the same carrier, since these options always differ significantly in both benefits and premium.)

Federal retirees in areas covered by participating HMOs have additional plans from which to choose. Thus, while a retiree in North Dakota or Wyoming may “only” have twelve plan choices, a retiree living in or near medium and large size cities in almost all states will typically have several more plan options. In the larger metropolitan areas, where the great majority of both Medicare and FEHBP retirees reside, there are often about 20 plan choices available to Federal retirees.

*Rural Access.* Of particular concern to rural Americans is the absence of plan choices in the areas in which they live. One recent analysis by the Rural Policy Research Institute (RUPRI) shows that . . . under Medicare+Choice, only 7 percent of rural counties offer Medicare beneficiaries any choice of plan beyond traditional Medicare.<sup>12</sup> In contrast, using an overly conservative methodology that significantly understates choice in the FEHBP (by using enrollment levels rather than actual plan availability), the RUPRI study finds that 87 percent of rural counties enroll Federal employees and retirees in 6 or more plans, and 98 percent in 3 or more plans.

Another study attempts to minimize the FEHBP’s strong rural access by claiming that “unless participants in more isolated areas are willing to travel long distances or pay extra amounts for care, they may find that only one or two plans offer meaningful access to services.”<sup>13</sup> This analysis focuses on Lebanon, Kansas, and states that only 2 plans (actually, 4 plans because the analyst erroneously ignores dual plan options) offer preferred primary care providers within 25 miles. This is true. But three of the dismissed FEHBP plans (including NALC and the two Mail Handlers plans) use the FirstHealth network and offer 694 preferred physicians and clinics within 50 miles, a seemingly large total for a town that is not within one hundred miles of a metropolitan area. Further, why should these and other plans be dismissed cavalierly when they in fact will pay 70 or 75 percent of the charge for ANY physician in or near Lebanon simply because this requires participants to “pay extra amounts for care” compared to the less costly preferred provider rate? Why is 75 percent reimbursement of reasonable physician charges characterized as less than “meaningful access” to services?

Regardless of how one characterizes access in Lebanon, Kansas, a proper comparison would cover far more rural areas. After all, preferred provider networks vary



from place to place and any one network is not equally comprehensive everywhere. Furthermore, the fundamental access problem for rural Americans encompasses not just primary care, but also specialist care and hospitals. One of the interesting areas in the RUPRI analysis is Kenedy County in southwest Texas. This county has fewer than 500 residents. RUPRI scores it as one of the 2 percent most underserved areas in the FEHBP because Federal employees and annuitants among these residents have signed up for no more than two plans.<sup>14</sup> Residents of Sarita, the primary town in this county, have no physicians or hospitals that are preferred providers within 20 miles under the FirstHealth network. But Kenedy County is only one county removed from Corpus Christi. Using a 50 mile radius search that reaches that metropolitan area, Sarita residents have 13 hospitals and 694 physicians and clinics available under the supposedly inferior FirstHealth network.<sup>15</sup>

FirstHealth may not be quite as comprehensive as Blue Cross or some of the other FEHBP networks. But it does contract as preferred providers with over 4,000 hospitals and almost 400,000 ambulatory providers. With this kind of reach, it obviously provides substantial preferred provider access to virtually all rural residents of the United States. The same can be said for all of the provider networks used by the national FEHBP plans.

*Benefit Innovation.* The importance of plan choices, of course, goes far beyond serving patient needs for provider choice and benefit options. The fundamental model of the FEHBP, like most services in our economy, relies on competition in attracting consumers as the driving force for both quality improvements and restraint of costs. For example, plans are free to add, drop, increase, or decrease deductibles. These are not trivial decisions. Deductibles have substantial effects on consumer acceptance, on premiums, and on health care utilization. Plans that strike the right balance do best over time. The fact that wide variations in deductibles persist over time suggests that there is more than one “right” model.

In fact, most plan benefits are quite stable. Deductibles are not frequently changed. But some benefits do change rapidly in most plans. Notable for experimentation and change are plan payments for prescription drugs. Ten or fifteen years ago, most plans either charged a nominal copayment or a modest coinsurance percentage for all drugs. Enrollees were free to go to the drug store of their choice. Mail order and formularies were almost nonexistent. In the last decade, with ever increasing spending on drugs—reflecting mainly new drugs with major new therapeutic benefits—plans have vigorously changed their approaches. Today, most plans have a six-tier benefit structure for drugs. There is one set of copayments for mail order, and another somewhat higher set for using preferred pharmacies. Generic drugs cost the enrollee the lowest copayment, preferred name brand drugs on the formulary somewhat more, and other name brand drugs the most. One can only imagine the political turmoil and potential for unnecessarily costly or constraining decisions were price controls and formularies to be proposed as features of a Medicare drug benefit. (Perhaps one had better say: just look at the last several years of political paralysis!) And it is inconceivable that such a benefit, once enacted into law under the standard Medicare approach, would receive the kind of nimble evolutionary adjustments used in the FEHBP as plans jockey for the best mix of generosity and cost control to attract customers.

Current FEHBP drug benefit structures place both the burden and the opportunity for decision making on the enrollee. They encourage frugality, but allow for medical necessity. They have evolved virtually without political controversy or legislative or bureaucratic fiat. And these approaches to benefit design have been proven to keep down drug spending and save both the payer and the enrollees a great deal in premium costs.<sup>16</sup> Based on RAND research, I estimate that the annual savings to the FEHBP from current tiered payment systems is somewhere around \$500 million annually, about 2 or 3 percent of program-wide premium costs, shared by the government and enrollees.<sup>17</sup> Additional savings from the use of Pharmacy Benefit Managers may equal or exceed those from tiered copayments.<sup>1</sup> **Adoption and continuing reform of prescription drug and other benefits in the FEHBP has been politically and programmatically painless, while saving billions of dollars over time.**

Open Season is the annual opportunity for Federal employees and annuitants to “vote with their feet” by switching plans. Although only about 5 percent elect to change plans each year, this provides relentless and continuing pressure on all plans to adapt and improve services while controlling costs. In contrast, most private employers frequently attempt to lower costs by changing their single plan from one insurance company to another. This imposes major disruptions on their employees, who are forced to change physicians when involuntarily transferred from Plan A to Plan B. Paradoxically, the seemingly radical FEHBP system of continuous competition is in far more stable. This stability benefits enrollees not only directly and

immediately, but over time, since plans retain incentives to invest in preventive care today to avoid higher expense years down the road.

*Consumer Satisfaction.* Consumer satisfaction is very difficult to measure fairly, and there may be no studies that directly compare Medicare to the FEHBP using elderly persons as the sample universe. However, we have some important information. OPM has innovated in the use of quality information in the FEHBP program, and led the way to adoption of participant surveys. By providing this information to enrollees, OPM has significantly aided them in plan selection. These surveys focus mainly on specific dimensions of plan performance, such as getting needed care, how well doctors communicate, and claims processing, but also measure overall satisfaction. The most recent survey information shows that on a scale of 1 to 10, about 79 percent of FFS and PPO enrollees and 63 percent of HMO enrollees rate their plans 8 or higher.<sup>18</sup>

We also have information from the annual Open Season, in which enrollees decide whether to stay in their plan or “vote with their feet” by moving to another plan. Each year, fewer than 10 percent of employees and fewer than 5 percent of retirees elect to switch plans. **The overall level of enrollee satisfaction with the FEHBP is clearly very high.**

A recent Commonwealth Fund Survey of Health Insurance did compare Medicare and private insurance.<sup>19</sup> It found that 85 percent of Medicare elderly rated their plan as good, very good, or excellent. In contrast, “only” 81 percent of those privately insured and of working age rated their plans as highly. However, these results really prove nothing. It is well known that plan satisfaction increases with age of respondent. Younger enrollees are far more critical. This largely explains the differential between FFS and PPO ratings in the FEHBP, since the HMOs disproportionately attract younger enrollees. HMOs enroll 40 percent of Federal employees but only 10 percent of retirees. In the Commonwealth survey, an 81 percent favorable rating by those aged 19 to 64, compared to 85 percent favorable among those aged 65 or more, arguably shows that **private health plans would actually be rated by consumers far higher than Medicare if available equally to each age group.** Finally, the reported results failed to distinguish between the elderly enrolled in Medicare alone, without any supplementary benefits, and the roughly nine out of ten who have supplemental plans including, among others, retirees simultaneously enrolled in the Medicare and the FEHBP (an extraordinarily rich benefit combination). Thus, the results say nothing at all about satisfaction with traditional Medicare standing alone. Indeed, the survey shows that the Medicare disabled, a younger group much less likely to have a supplemental benefit, give Medicare only a 66 percent favorable rating. Thus, among the respondents who are below age 65, Medicare scores far worse than private plans.

Another recent survey, sponsored by the American Association of Health Plans offers additional evidence on seniors’ views of health plans.<sup>20</sup> This survey, whose respondents were exclusively elderly, found that 72 percent of seniors enrolled in traditional Medicare believed that a choice of plans was important (among M+C enrollees, this percentage rose to 88 percent). On a variety of measures of plan satisfaction, enrollees in traditional Medicare and M+C showed essentially identical satisfaction levels. For example, 82 percent of the former and 79 percent of the latter were very or somewhat satisfied with the benefits they received. One would expect this result since the overwhelming majority of the former group has supplemental benefits and presumably responded on the basis of their total benefit package. Just as for the Commonwealth survey, one can reasonably assume that those enrolled in traditional Medicare alone and without either supplemental benefits or an M+C option would have registered far lower satisfaction levels.

*Guaranteed Benefits.* The FEHBP and Medicare programs differ fundamentally in several ways, one of which is the difference between a “premium support” as opposed to “defined benefit” structure. An HARP study argues that the Medicare approach is better because the benefits are “entitlements” that are “protected” because defined in law.<sup>21</sup> This line of argument is fundamentally flawed in three ways.

First, statutorily defined benefits can be taken away whether or not defined as legal entitlements. The Medicare deductible used to be defined by law at \$50 but is now \$100. The Congress once enacted prescription drug benefits and then repealed them. Indeed, the Congress amends the Medicare statute every year. As the program steadily progresses toward insolvency, maintenance of current benefit levels hardly seems assured. Relatedly, the FEHBP is just as much an “entitlement” as Medicare. It is simply handled a different way. **The FEHBP premium level is “protected” by being defined in law and the “entitlement” formula that defines the premium level provides a substantially better level of insurance benefits than Medicare.** The entitlement says, in essence, that the government pays 75 percent of the average cost of plans that enrollees voluntarily choose. In-

deed unlike Medicare the FEHBP statute has never been amended to reduce enrollee benefits.

Second, FEHBP benefits have been superior to those of Medicare for decades. The “defined benefit” turns out to be no more than a guarantee for a second rate product, and the allegedly weaker “premium support” guarantee has proven a superior guarantor of benefits by actual experience.

Third, both premiums and benefits can be guaranteed in statute without using the “enumerate every benefit in excruciating micro-managed detail” approach used by Medicare. Enrollees can be guaranteed by law an actuarially reasonable value of benefits, both overall and in broad categories such as hospital or drugs. Within such a constraint(s), plans can make the decisions as to which deductibles (if any) to use, where to set deductible levels, where to set copayment and coinsurance levels, whether or not to tier benefits, which treatments to accept as medically proven, where to set the catastrophic guarantee level, etc. In fact, this is essentially the way that OPM operates the FEHBP. The FEHBP statute could be amended to make the actuarial fairness and soundness tests explicit guarantees better than those of Medicare, without changing the program in any way. **The “premium support” model used by the FEHBP has proven to be both better and safer as an entitlement than the “defined benefit” Medicare model.**

*Consumer Understanding.* It has often been alleged that consumers, particularly elderly consumers, cannot handle the complications of a competitive plan system. After all, it is claimed (and true) that many consumers do not understand traditional Medicare itself.<sup>22</sup> While by definition choice certainly is more complicated than no choice, there is no evidence that consumer choice poses any more of a problem for health insurance than for any other product or service. The elderly choose their own doctors, their own automobiles, their own foods, and their own living arrangements. Any or all of these are as or more complicated than health insurance. Bizarrely, discussions of this topic often contain no, or minimal, references to the rich informational resources available to one and half million Federal retirees.<sup>23</sup>

Furthermore, criticisms of plan choice implicitly assume that traditional Medicare poses little or no information burden. In fact, traditional Medicare creates difficult informational problems and choices.<sup>24</sup> For example, most persons, upon turning age 65, have a choice among various Medigap plans, yet receive little or no information from Medicare or any other source as to the value of such plans individually or compared to one another. Low income beneficiaries may be eligible for Medicare supplementation and premium payments, yet are rarely informed of these benefits and if they attempt to explore them are faced with the daunting welfare bureaucracies that administer Medicaid. Hundreds of thousands of older workers are not even eligible for Medicare but do not know it (these are, typically, state employees hired before 1986).<sup>25</sup> Errors in Medicare decision making expose the elderly to financially disastrous mistakes. So serious are these problems that one analyst calls for new informational campaigns and for reforming State application processes. Without waiting to reform Medicare, we should “act now to fix the programs that we already have in place”.<sup>26</sup> In contrast, the FEHBP program poses few “gotchas” and is essentially free of complex decision issues. The worst potential financial error arises from the requirement that enrollees participate continuously in the program for five years before retirement to retain benefits after retirement. The most complex decision is the choice at age 65 as to whether or not to enroll in Medicare Part B to supplement the FEHBP benefit. (It turns out that Medicare Part B is a bad financial buy for Federal retirees turning age 65, but one virtually forced on them by unnecessary financial penalties and the uncertainty of future political decisions.<sup>27</sup> In the FEHBP, unlike traditional Medicare, errors in plan enrollment decisions and changing circumstances can be remedied or accommodated each year in the annual Open Season.

To be sure, Federal employees and retirees are on average better educated than Medicare beneficiaries. Working Americans, on average, are better educated than the elderly and far less likely to suffer mental impairments. But no system of choices in our society, whether choices of friends, spouses, foods, automobiles, or anything else depends on every single consumer being smart and well informed. As the inevitable errors occur, we accept that as the price of individual autonomy in decision making.

Most fundamentally, criticisms of choice based on decision complexity create a ridiculous standard. How many consumers of any age or educational level understand the innate workings of automobiles—the physics of and technology used in engine, transmission, braking, and other systems? Yet, somehow, through magazine ratings, recommendations of friends, test drives, modest government oversight and regulation, past experience, and above all the pressures of a competitive market place, the elderly are overwhelmingly able to select and use cars that are effective, durable,

safe, comfortable, and economical. Should we ban competition in the automobile industry because some consumers are ignorant or uninformed or even incapable of understanding certain complexities and a few make bad choices? And why stop at automobiles? The entire economy rests on consumers making choices among tens of thousands of competing goods and services, choices that are analytically complex beyond even the abilities of *Consumer Reports* to simplify in its relative handful of comparative analyses. Somehow, despite all these complexities, it is seemingly only health insurance that is held forth by critics as the one service that will overwhelm cognitive abilities, and choice among plans as the one decision that consumers cannot be trusted to make.

Competitive choice among health plans is certainly facilitated by careful oversight and information dissemination. OPM has proven to be effective in these matters, and the private market has provided additional information that consumers and those family and friends who advise them can use effectively. See the latest *CHECKBOOK's Guide to Health Plans* ([www.retireehealthplans.org](http://www.retireehealthplans.org)), and the OPM Web site ([www.opm.gov/insure/health](http://www.opm.gov/insure/health)) for thorough and user friendly displays of information. These formal and organized information sources, of course, are not those that most consumers primarily rely on. Instead, they use their own experience, and the experience of friends and neighbors, and above all the market driven menu of good options they face, to make annual decisions among plans. Since most FEHBP plans are excellent choices, overwhelmingly satisfying enrollee preferences for benefits, provider choices, responsiveness, and cost, 95 percent or so make the simplest possible choice each year: remaining in the same plan. To be sure, the elderly do not have coworkers to advise them on plan selection, in contrast to Federal employees.<sup>28</sup> But seniors have information networks of their own, including an extensive system of counselors located in Area Aging Agencies.

Confusion in choosing among competing products has simply not been a problem for the millions of Federal annuitants who, over the years, have benefited from their plan selection decisions. **Should Medicare be reformed into a pro-consumer choice system, assuring adequate information will not be difficult if the OPM approach is emulated, and the private sector encouraged to supplement government information.**

*Adverse Selection.* Some argue that any form of multiple plan choice will necessarily lead to destructive risk selection and unpredictable exit and entrance of plans—the dreaded “death spiral.” Certainly the FEHBP has no system of any kind for managing risk selection.<sup>29</sup> In contrast, Medicare ceaselessly searches for improved methods of fine-tuning its risk management features. Reform of the AAPCC (Adjusted Average Per Capita Cost) system was delayed for a decade or more because no one could devise a perfect system. The long delayed reform failed again to correct the fundamental problem that well managed health care does not in fact cost half again more in Miami than in Des Moines, or in Prince Georges County than in Fairfax County among the Washington suburbs.

There is even a respectable argument that some risk selection is desirable. For example, if people with dental problems tend to join plans with better dental benefits, willingly paying the full marginal cost of their decision, what ethical or managerial principle is violated?

The FEHBP has survived for four decades with no management of risk selection other than the stability inherently produced by its insurance subsidy. A recent study by eminent economists concluded that the program has almost no measurable adverse risk selection.<sup>30</sup> An amateur study, more critical, nonetheless concluded that “FEHBP’s stability may amount to stable biased selection.”<sup>31</sup> Whatever circumstances may lead to the “death spiral”, they do not obtain in a plan choice program designed along the lines of the FEHBP. Amusingly, program critics like to cite the single example of the departure of the Aetna FFS plan from the program in 1990. The fact is that Aetna was dropping all of its FFS products at that time, and found its increasingly marginal FEHBP position a handy excuse to drop out of the program.

*The Medicare+Choice Experience.* Some claim that because Medicare+Choice has had a rocky start, and failed to reduce overall Medicare costs, consumer choice has been tried and has failed. However, under the reimbursement formula used in that program, relying on the fundamentally flawed AAPCC estimates of geographic variability in health costs, and tied to the yo-yo of annual changes in Medicare spending levels, Medicare+Choice never had a chance to perform properly.<sup>32</sup> Indeed, an important and mostly ignored research study has demonstrated that geographic variations in managed health care costs are minimal, rarely exceeding a 10 percent variation above or below the national average anywhere in the country.<sup>33</sup> A well designed defined contribution program using rolling averages or all-plan averages and minimal geographic adjustments (if any) would have functioned far better. In addi-

tion, a set of draconian and unreasonable mandates made participation expensive and burdensome for any FFS or PPO plan, and for most HMOs. One regulatory mandate, for language interpreter services paid by each plan, is arguably illegal in at least three different ways.<sup>34</sup> Incredibly, despite these problems Medicare+Choice still manages to attract about 150 plans and almost 5 million enrollees, about 1 in 8 Medicare clients.

Regulatory mandates, unreliable funding levels, constant change, unrealistic government expectations, and other rocky issues have led to perhaps the most fundamental problem of M+C. Health plans do not regard Medicare (both CMS and the Congress) as a good business partner. Even the promise of substantial additional business has proven a weak incentive in the face of the underlying distrust, distrust based on a well known track record.

A program that made it financially infeasible for HMOs in most of the Midwest to participate, and that has even forced Kaiser plans to withdraw, is a fundamentally flawed program. Furthermore, the OPM/plan relationship is one of steady cooperation and predictable behavior. **The FEHBP shows far better ways than Medicare+Choice to implement effective plan choice.**

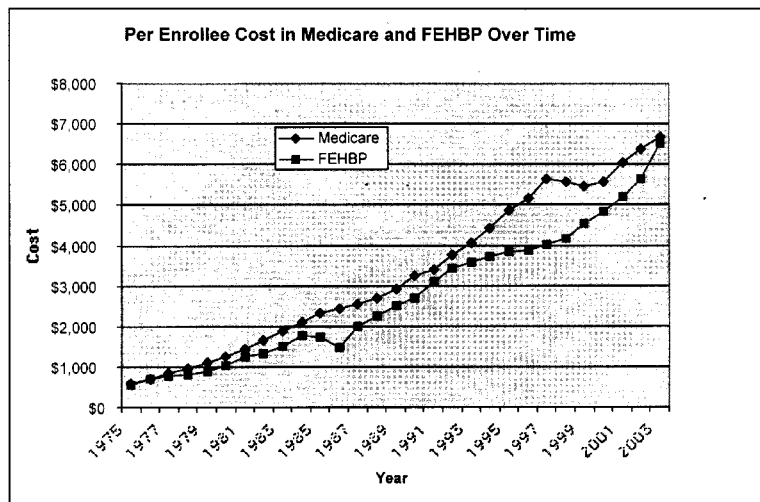
*Cost Control.* The last comprehensive examination of cost control found, surprisingly, that the FEHBP had actually controlled costs slightly better than Medicare.<sup>35</sup> My updated analysis now shows that the two programs roughly tie when costs are looked at without regard to benefit changes. However, when benefit improvements are taken into account, **the FEHBP maintains its superiority in cost control.**

Each program has good years and bad years, and these do not correspond in any simple way. By careful selection of base year, it is easy to "prove" that one program outperforms the other. And depending on whether the comparison covers one, three, five, or ten years, the answer is very different. To get around these problems, one good method is to use multiple rolling averages covering 10 years. This shows long term performance without the noise that affects shorter comparisons. One needs multiple ten year comparisons because the latestone can be (and usually is) unduly influenced by a particular good or bad base year in one program or the other. The table below shows the latest results, all taken from publicly available budgetary data covering 28 years (the raw data are appended at the end of this testimony).

Ending in Fiscal Year	Medicare 10 Year Record	FEHBP 10 Year Record	Difference	Cumulative Difference
1985	15%	12%	-2%	-2%
1986	13%	8%	-5%	-7%
1987	12%	10%	-2%	-9%
1988	11%	11%	0%	-8%
1989	10%	11%	1%	-7%
1990	10%	11%	1%	-6%
1991	9%	10%	1%	-5%
1992	8%	11%	2%	-3%
1993	8%	10%	2%	-2%
1994	8%	8%	0%	-1%
1995	8%	9%	1%	0%
1996	8%	10%	3%	3%
1997	8%	7%	-1%	2%
1998	8%	6%	-1%	1%

1999	7%	6%	0%	0%
2000	6%	6%	0%	1%
2001	6%	5%	-1%	0%
2002	5%	5%	0%	0%
2003 est	5%	6%	1%	1%

What these data show is that in recent years both programs have had a 10 year average cost increase of around 5 or 6 percent a year, and that even over the full set of comparisons the programs have only differed by more than a percentage point a few times. Measured this way, the cumulative difference over comparisons covering 28 years of data is a one percent advantage for Medicare.



Another way to view relative performance over time is to chart the average cost per enrollee, using the same data quoted above. As shown below, the FEHBP and Medicare both started and ended at almost exactly the same levels over the 28 year period. However, during this period the FEHBP was consistently below the Medicare level, often by substantial amounts, and hence cumulatively saved substantial amounts compared to what it would have spent had its trajectory matched Medicare's. This comparison does **not** include adjustments for improvements in FEHBP benefits over time.

The data end in FY 2003 because the budgetary projections for 2004 are unreliable for both programs. However, Medicare's chief actuary has recently announced that there is an unexpected increase of 12% in Medicare Part B costs for 2004. Using later estimates for both programs, the FEHBP would likely have outperformed Medicare in the cumulative comparison. **In summary, the FEHBP and Medicare programs have virtually identical records over time on keeping cost increases down, despite substantial and costly benefit improvements in the FEHBP. Put another way, were benefit improvements used to adjust cost figures, the FEHBP unambiguously outperforms Medicare in cost control.** In recent years, however, Medicare has had an advantage and the future performance of these programs is almost impossible to predict. One substantial problem facing the FEHBP is that with recent increases in government cost sharing, enrollees pay only about 17 percent of premium costs, and incentives to attenuate cost and premium differences are greatly attenuated from those of past years.<sup>36</sup>

It should not really be surprising that the records are broadly similar, since both programs operate in the context of the American health care system, with the same underlying structure of hospitals, doctors, costs, technological changes, and a myriad of other commonalities.

However, viewed another way, there is a surprise. The Medicare Administrator operates a system of price controls. As the Congress has so amply demonstrated in its recent flip flop attempts to set physician, hospital, and Medicare+Choice reimbursements at the "right" levels, determined in large part by the decibel level of the

political outcry, price controls can be set arbitrarily within a fairly broad range. Thus, Medicare could outperform the FEHBP in reducing premium costs through cutbacks in provider prices and income, through benefit reductions, and through other government-mandated reductions. Health care resources, both human and bricks and mortar, are not in the short run perfectly mobile. Thus, the Medicare budget is set ultimately by what the political system tolerates, not by the market or any objective method.

There is also the pertinent question of how Medicare compares to the private sector's cost control experience generally. One recent study claims that "Medicare can be counted on to control per enrollee spending growth over time, more than private insurers can".<sup>37</sup> This study relies on a comparison of Medicare and private insurance payment data derived from National Health Accounts data provided by the agency that administers Medicare. The data purport to show that since the mid-1980s Medicare has consistently outperformed the private sector in controlling spending on comparable services (e.g., excluding prescription drugs because these are not covered by Medicare). Another analysis uses the National Health Account data together with data from the National Medical Care Expenditure Survey (MEPS) and other sources to demonstrate that when cost increases are adjusted for benefit improvements, the private sector at large has outperformed Medicare over the last 30 years.<sup>38</sup> In other words, **whether looking at private spending in general, or the FEHBP in particular, benefit-adjusted private sector costs have increased less than Medicare costs over most or all of the life of the Medicare program.** In the case of the FEHBP, its cost growth is so superior that it ties or slightly outperforms Medicare even without adjusting for benefit improvement over time.

This cost control performance has come despite (or because of) higher administrative costs for the FEHBP, despite paying physicians and other providers more than Medicare,<sup>39</sup> and despite the near absence of direct managerial controls. One reason, of course, is that Medicare lurches from one crisis to another as both consumers and providers find ways to game the system. In the FEHBP, plans ceaselessly find ways to speedily control unnecessary spending, relying on a wide range of techniques. OPM can urge plans to adopt useful innovations by simple letter requests, unencumbered by the *Federal Register* process used by CMS, which on average requires years from inception to final publication of binding rules. For example, it took years of regulatory indecision, and ultimately an Act of Congress, to stop Medicare payment for unnecessarily expensive seat lift chairs, once routinely prescribed by doctors for patients who saw beautiful and expensive lounge chairs advertised on television as covered by Medicare. In the FEHBP, OPM was not involved, and plans simply refused to pay for anything other than the most austere models of seat lifts, relying on "reasonableness" clauses in their policies.

*Approaches to Medicare Reform.* I have attempted to address each of the major areas in which fundamentally different approaches to health insurance programs can be compared. On each dimension of performance, the FEHBP is arguably at least equal, and usually superior, to Medicare as currently constructed. This doesn't lead to any simple conclusion as how best to reform Medicare. The issues are many and complicated. And it certainly does not mean that the FEHBP program is perfect—it has many important problems. Several of these, to which I hope this Committee can attend, are embodied in the Medicare statute. There is a senseless and costly restriction in Medicare law prohibiting FEHBP plans (and no other employer plans) from paying Part B premiums. That restriction costs both Medicare and the FEHBP a good deal of money because it forces plans to offer unusually high benefit wraparounds rather than offer lower premiums, which leads to unconstrained utilization incentives. A second problem is the needless 10 percent a year penalty imposed on late enrollment in Medicare Part B. This penalty is imposed even if the enrollee is covered by comprehensive insurance and the possibility of adverse selection is remote. Lifting this restriction for those covered by comprehensive plans would induce more elderly to remain in employer sponsored retirement plans, thereby directly reducing Medicare costs.<sup>40</sup>

**My testimony is not intended to suggest a blueprint for actual Medicare reform. Obviously, the FEHBP model cannot and should not be adopted in every detail or even every major feature. Many carefully analyzed decisions would have to be reached to make an FEHBP-like system a viable Medicare model. However, certain pitfalls and solutions are obvious.**

1. Above all, the FEHBP is a good business partner. The rules of the game are few, robust, and rarely changed. In sharp contrast, the next wrenching Medicare reversal is rarely farther away than the next Congressional session. To succeed, Medicare reform must provide for reasonable assurance of stable and growing payment rates, stability of plan participation (no risk of being evicted from the program if

a plan's premiums go up just slightly "too much" next year), freedom from both costly mandates and nuisance regulations, and other significant changes from current practice.

2. The FEHBP provides a reasonable and predictable level of financing to health plans. Again in sharp contrast, Medicare+Choice has been greatly hampered by its reliance on the annual level of spending in traditional Medicare, and the reliance on the absurd assumption that widely varying levels of per capita health care spending from county to county are even an imperfect proxy to the costs of delivering managed health care. Unfortunately, reliance on competitive bidding in any form is likely to introduce unpredictable results, with plan participation varying unpredictably depending on the annual bidding decisions of other plans. Surely a better approach can be devised, such as a government payment level based on a rolling average of prior costs in traditional Medicare, and allowing plans to charge whatever premium they must in order to cover their costs while attracting enrollees. Ideally, such a payment would be level, or nearly so, throughout the country.

3. The FEHBP lets plans decide benefit and coverage details, and Medicare should as well. Many otherwise astute students of reform have suggested that competing plans should have identical benefits, specified in detail by the government.<sup>41</sup> However seemingly attractive this idea may be in terms of simplifying decisions for enrollees, it would be a fatal mistake. It would transform what would otherwise be private decisions on a myriad of benefit details into government decisions on the details of the uniform benefit structure, just as under traditional Medicare. Because those government decisions would be made through bureaucratic processes and often on political grounds, rather than through evolving consumer choices and plan responses, the essential mechanisms of timely benefit innovations and cost control would be destroyed. Requiring all plans to adhere to government-specified benefit details would be roughly comparable to requiring all automobile manufacturers to follow uniform "one size fits all" government specifications as to size, seats, horsepower, cup holders, paint colors, and all the other myriad features that today distinguish one model of car from another. There are obvious alternatives to detailed benefit specification, such as providing benefits that, in total, meet an actuarial test.<sup>42</sup> This test should be applied to core benefits, not just extra benefits. No plan should have to meet the precise parameters of Medicare Parts A and B for hospital and outpatient services, when these are so often unnecessarily costly, limiting, or arbitrary.

Benefit standardization would also be unnecessary for consumers. As discussed previously, there is no persuasive evidence that product standardization is any more necessary for understanding health plans than for any other service or product in the economy.

4. Service areas and preferred provider depth within them should be flexible. Some have suggested that plans be required to have identical service areas specified by the government.<sup>43</sup> The rationales are that if every plan has an identical service area specified by the government, it will not be able to cherry pick the healthiest, that rural areas will be better served, and that employee choice will be simplified. These are purely hypothetical advantages, and the latter fails even the laugh test. Modern Internet technology allows every single enrollee to receive or create plan comparisons based on his or her zip code, without regard to what other areas the plans cover. The CHECKBOOK and OPM web sites for Federal employee plan choices organize and present plan comparisons by geographic area. Furthermore, in the real world plans serve, and enrollees live in, reasonably well defined areas. Anyone can understand that plan A covers all of New Jersey, plan B all of New York and New Jersey, and plan C the metro New York area in those states and in Connecticut. The cherry picking argument deals with a nonexistent problem that has never emerged in the history of the FEHBP.

Uniform boundaries could create an administrative disaster, and would certainly preclude the participation of many and perhaps most HMO plans and other small plans specializing in particular areas. In effect, the government would be telling Kaiser and every other HMO that it has to cover a named multi-state area (perhaps defined in terms of the existing 10 Federal regions), even if Kaiser cannot and will not build or find a network of that size or covering those precise areas. These problems might be less if uniform areas were applied only to PPOs rather than HMOs. However, even here problems could abound if plans were not allowed to provide service outside these areas, or were forced to expand networks in unnatural ways. Thus, the government would presumably require West coast plans to cover Alaska and Hawaii, require plans based in Hawaii to cover the West coast, and ditto for Puerto Rico and the mid-atlantic region. A Pittsburgh plan in the mid-atlantic region might be forbidden from covering Ohio residents, just down the Ohio river, because they would be located in the mid-western region. Even the Blue Cross system,



with its ever-evolving boundaries, might have to restructure its service areas throughout the nation to meet the Medicare boundaries.

These are not hypothetical issues. The government sponsored system for organ allocation, the Organ Procurement and Transplantation Network, is plagued with problems created by its system of geographic regions. As an example, patients on waiting lists in the Omaha metropolitan area who live on the Iowa side of the Missouri River are forced to travel to distant Iowa cities to obtain organs, simply because Nebraska and Iowa fall in different regions in the OPTN system. The Medicare Prospective Payment system has extensive problems in determining boundaries among reimbursement areas. No system of service or payment limiting geographic boundaries can avoid anomalies like these. Moving the boundary from one place to another simply moves the locus of error and controversy. Allowing for exceptions (e.g., Puerto Rico plans can appeal to Medicare not to have to cover the mainland) simply creates another burdensome bureaucratic process and would ultimately lead to a tangled mess.

Nor are geographic restrictions needed to promote rural access. Nothing in either logic or FEHBP experience suggests that every single plan need provide the same depth of provider networks in every geographic subunit. The robust FEHBP performance in Lebanon, Kansas, and Sarita, Texas, shows that there is no compelling reason why every plan in any area has to offer equally broad provider networks to assure good rural access. In most remote areas several plans will offer good provider panels, even if all do not. And why wouldn't plans, anticipating some out of plan use, generally provide for FFS benefits along with preferred provider benefits, as in the FEHBP? Most importantly, requiring every plan to offer equal access will restrict the number of plans willing to offer services in a given area, and reduce the ability of plans to manage their networks efficiently. In other words, **a requirement for "one size fits all" minimum standards for geographic coverage and access could deprive, not foster, enrollee choice of plans and providers, while driving costs borne by enrollees higher than necessary.**

These arguments are not meant to suggest that geography play no role in reform, but that any provisions need to be carefully crafted to assure that they do not create more problems than they solve.

5. Surely participating plans should be exempt from state mandates, as are the national plans in the FEHBP. The FEHBP also limits state regulation of HMO benefits to those of the home state, not every state in which the HMO operates. Thus, the Kaiser plan of the mid-Atlantic enrolls Federal members from six jurisdictions, but must meet only Maryland, not Delaware, DC, Virginia, Pennsylvania, or West Virginia mandates.

6. Obviously, Medicare reform must meet short and long run budgetary objectives. Painful compromises on generosity of benefits are necessary. But if cost constraints force an unduly parsimonious approach to design of the reform package, along with "hole in the doughnut" prescription drug benefits, the entire purpose of reform may be jeopardized. Highly constrained and geographically bounded competitive bidding systems may have the unintended result of zero cost, simply because no sensible health plan will want to participate. In this regard, there is a player in the Medicare reform game who is rarely discussed: the large employers of America. These firms and governmental units will reap windfall reductions in post-retirement health insurance costs with the introduction of prescription drug coverage into traditional Medicare. There are ways to make that windfall smaller. For example, the tax deductibility of health insurance contributions to these firms could be conditioned on at least partial maintenance of effort for retirees, with the firms essentially being obliged to bear part of the cost of premium supplements for both old and new Medicare plans. Further, there are the aged themselves. In a program whose long term insolvency looms ever closer, increasing the proportion of costs borne by the elderly from its current small fraction seems obviously desirable, however much the elderly might prefer a free ride on taxes paid by working Americans. Moreover, the higher the nominal premium borne by the elderly, the higher the level of subsidy that large employers will find themselves forced to bear in subsidizing that premium. Low income elderly without retirement benefits from former employers can and should be protected through premium subsidies, either by improving current arrangements under Medicaid or through direct discounts based on prior year tax returns.

In this regard, I note that the original FEHBP model had employees and retirees bear 40 percent of premium costs, and that over time this inadvertently (due to a drafting error in the statute) decreased to about 28 percent. Recently added tax preferences have reduced the effective employee share to about 20 percent, but retirees still pay on average about 28 percent. In sharp contrast, the elderly pay rather less than 10 percent of the premium-equivalent cost of Medicare. Working age tax-

payers at all income levels, and to a lesser extent elderly and affluent taxpayers, pay the rest. The generosity of the FEHBP lies in its dynamic revision of the reimbursable cost basis for premiums, using an all plan average of current and projected costs, rather than in the percentage of premium that it pays.

7. As a final suggestion, why not allow the national FEHBP plans themselves to compete for Medicare business under a reform system? These plans could readily segregate finances and enrollment information for the two enrollee groups. Of course, they would not compete if they had to comply with cumbersome rules that would affect their benefits and coverages, their provider networks, their administrative costs, their ability to participate over an extended period of time without eviction from the program, or their autonomy under the FEHBP. Whether or not you adopt this somewhat whimsical idea; if the system that this Committee ultimately chooses would not readily accommodate participation by these plans, then I suspect it will fail.

*Conclusion.* A fundamental issue should be prominent in deciding among reform options and alternatives. The Medicare program is overwhelmingly statist. Medicare uses political fiat, price controls, and centralized bureaucratic processes to try and regulate an infinitely complicated trillion dollar health care market. Every decision that Medicare makes is necessarily a compromise that is wrong, often deeply wrong, for large numbers of enrollees and providers. Medicare is like a government designed automobile (actually, we have had two of these: the jeep and the Humvee). Designed by committee, changed too late, final details set by legislative or bureaucratic fiat, based on the principal that “one size fits all” and the corollary ethical proposition that every one should get an identical benefit because anything else is “unfair”, Medicare lurches along like a grounded Dumbo the elephant. Like the jeep and the Humvee, it fits very few as well as the plan (or auto) they would choose for themselves, if offered a choice.

In contrast, the FEHBP uses the mildest forms of government direction and oversight to allow the forces of choice and competition to determine health plan costs, benefits, provider choice, administrative convenience, and a host of details. As a final example, every single FEHBP plan covers health care anywhere in the world (HMOs offer care anywhere outside the plan area for emergencies). Why is this? Because very few consumers would voluntarily enroll in a plan that didn’t offer this feature, even if they had no travel plans. If this feature cost a great deal, some plans would decline to offer it to their members, seeking to attract the “stay at home” group. The fact that hundreds of health plans do not act this way demonstrates that the extra costs of this feature are small. Why then does Medicare not offer this benefit? And why do most of government prescribed and designed Medigap plans not offer this benefit?

Obviously coverage abroad is a far less important issue than prescription drug coverage and many others (though not less important to former immigrants who wish to live in retirement in their lands of origin, without giving up their health insurance or being forced to buy an exorbitantly expensive Medigap supplement). But a program run on the bureaucratic regulatory model necessarily fails to deal optimally with many problems both large and small. Indeed, we all know that the chief impediment to a Medicare drug benefit is that the Medicare program is a price control program run along draconian lines not seen elsewhere in most of the American economy since World War II. Price controls are anathema not only to the pharmaceutical industry, but also to all of us who expect that cures for Alzheimer’s disease (and many others) are likely only from a profit-driven industry free to charge “high prices” without government price controls.

The choice before the Congress ultimately is between these two models—consumer choice or detailed legislative and bureaucratic control of benefits and prices. The Food Stamp program has long demonstrated that it is possible to have a government entitlement that leaves purchasing decisions almost entirely with consumers rather than legislators or bureaucrats. By good fortune we have as a health insurance example the successful performance of the consumer choice model in meeting the needs of 9 million Federal employees, retirees, and family members. Surely we can use that model to aid in reforming the Medicare program.

## Appendix: FEHBP AND MEDICARE COST CONTROL OVER TIME

FY	Medicare Part A	Medicare Part B	Total Cost per enrollee	Annual M'care Increase	Ten Year M'care Ave.	FEHBP Obligations	End of Year FEHBP Enrollees	Total Cost per Enrollee	Annual FEHBP Increase	Ten Year FEHBP Ave.
1975	\$434	\$161	\$595			\$1,753	3147	\$557		
1976	<i>\$512</i>	<i>\$203</i>	\$715	20%		\$2,239	3226	\$694	25%	
1977	\$589	\$245	\$834	17%		\$2,600	3297	\$789	14%	
1978	<i>\$680</i>	<i>\$288</i>	\$968	16%		\$2,808	3393	\$828	5%	
1979	<i>\$772</i>	<i>\$331</i>	\$1,103	14%		\$3,150	3491	\$902	9%	
1980	\$863	\$374	\$1,237	12%		\$3,674	3598	\$1,021	13%	
1981	<i>\$1,008</i>	<i>\$446</i>	\$1,454	18%		\$4,653	3684	\$1,263	24%	
1982	<i>\$1,153</i>	<i>\$518</i>	\$1,671	15%		\$4,980	3729	\$1,335	6%	
1983	<i>\$1,297</i>	<i>\$590</i>	\$1,887	13%		\$5,525	3641	\$1,517	14%	
1984	<i>\$1,442</i>	<i>\$662</i>	\$2,104	11%		\$6,583	3689	\$1,784	18%	
1985	\$1,587	\$734	\$2,321	10%	15%	\$6,482	3768	\$1,720	-4%	12%
1986	\$1,591	\$831	\$2,422	4%	13%	\$5,723	3847	\$1,488	-14%	8%
1987	\$1,592	\$969	\$2,561	6%	12%	\$7,714	3909	\$1,973	33%	10%
1988	\$1,630	\$1,070	\$2,700	5%	11%	\$9,016	4010	\$2,248	14%	11%
1989	\$1,765	\$1,158	\$2,923	8%	10%	\$10,169	4050	\$2,511	12%	11%
1990	\$1,970	\$1,282	\$3,252	11%	10%	\$10,922	4041	\$2,703	8%	11%
1991	\$2,009	\$1,381	\$3,390	4%	9%	\$12,657	4077	\$3,104	15%	10%
1992	\$2,315	\$1,445	\$3,760	11%	8%	\$14,024	4074	\$3,442	11%	11%
1993	\$2,546	\$1,524	\$4,070	8%	8%	\$14,546	4077	\$3,568	4%	10%
1994	\$2,783	\$1,658	\$4,441	9%	8%	\$15,218	4096	\$3,715	4%	8%
1995	\$3,063	\$1,788	\$4,851	9%	8%	\$15,515	4053	\$3,828	3%	9%
1996	\$3,289	<i>\$1,867</i>	\$5,156	6%	8%	\$16,148	4159	\$3,883	1%	10%
1997	<i>\$3,569</i>	<i>\$2,054</i>	\$5,623	9%	8%	\$16,557	4133	\$4,006	3%	7%
1998	\$3,493	\$2,066	\$5,559	-1%	8%	\$17,161	4120	\$4,165	4%	6%
1999	\$3,328	\$2,146	\$5,474	-2%	7%	\$18,654	4123	\$4,524	9%	6%
2000	\$3,190	\$2,370	\$5,560	2%	6%	\$19,662	4084	\$4,814	6%	6%
2001	\$3,408	\$2,652	\$6,060	9%	6%	\$21,143	4075	\$5,188	8%	5%
2002	\$3,588	\$2,777	\$6,365	5%	5%	\$22,820	4046	\$5,640	9%	5%
2003	\$3,667	\$3,024	\$6,691	5%	5%	\$26,461	4057	\$6,522	16%	6%

Notes: FEHBP amounts do not equal annual premium changes because of reserve payments and Open Season shifts. FEHBP data from U.S. Budget Appendix since FY 1982; earlier years from OPM annual Insurance Report. Medicare data before FY 1999 from Green Book; from 1999 forward from HHS Budget in Brief. Some years are interpolated; these are shown in italics.

<sup>1</sup> Francis, Walton. *CHECKBOOK's Guide to Health Plans for Federal Employees*. Washington, DC. Washington Consumers Checkbook. 2002. See retiree version at [www.retireehealthplans.org](http://www.retireehealthplans.org).

<sup>2</sup> Francis, Walton, *Testimony of Walton Francis, Author and Independent Consultant, Before the Special Committee on Aging, United States Senate*. May 6, 2003.

<sup>3</sup> Cain II, Harry P. 1999. "Moving Medicare to the FEHBP Model, Or How To Make an Elephant Fly." *Health Affairs*, July-August 1999. Online at [www.healthaffairs.org](http://www.healthaffairs.org).

- <sup>4</sup> Davis, Karen et al. 2002. "Medicare Versus Private Insurance: Rhetoric and Reality." *Health Affairs* Web Exclusive. Abstract in issue of November/December 2002; Online at [www.healthaffairs.org](http://www.healthaffairs.org).
- <sup>5</sup> Merlis, Mark. *The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform*. The Henry J. Kaiser Family Foundation. May 2003. Table 3 at page 9. Online at [www.kaisernet.org](http://www.kaisernet.org).
- <sup>6</sup> Merlis, Mark. *Medicare Restructuring: The FEHBP Model*. The Henry J. Kaiser Family Foundation. February 1999. Table 13 at page 36. Online at [www.kaisernet.org](http://www.kaisernet.org).
- <sup>7</sup> Merlis, 2003, page 2 and elsewhere, repeatedly states that only 6 plans are available when his own table 2 on page 4 shows 11 of the 12 plans available to all Federal employees and retirees (it would have shown 12 but for a factual error).
- <sup>8</sup> Medicare Current Beneficiary Cost and Use Survey, 2000 Access to Care file, on the web at [www.cms.gov](http://www.cms.gov).
- <sup>9</sup> Francis, Walton. "The Political Economy of the Federal Employees Health Benefits Program." *Health Policy Reform: Competition and Controls*, edited by Robert B. Helms. Washington DC. AEI Press. 1993.
- <sup>10</sup> Hoff, John. 1998. *Medicare Private Contracting: Paternalism or Autonomy?* Washington, DC. AEI Press.
- <sup>11</sup> Medicare Payment Advisory Commission. 2003. "2002 Survey of Physicians About the Medicare Program". Online at [www.medpac.gov](http://www.medpac.gov).
- <sup>12</sup> McBride, Timothy et al. An Analysis of Availability of Medicare+Choice, Commercial HMO, and FEHBP Plans in Rural Areas: Implications for Medicare Reform. 2003. Rural Policy Research Institute. Online at [www.rupri.org](http://www.rupri.org).
- <sup>13</sup> Merlis, 2003 *op cit*, page 13.
- <sup>14</sup> McBride *et al*, *op cit*, Map 3 on page 6.
- <sup>15</sup> All unpublished data on provider access in Lebanon, Kansas and Sarita, Kenedy County, Texas, are based on Web searches at FirstHealth, conducted June 4, 2003. See [www.firsthealth.com](http://www.firsthealth.com).
- <sup>16</sup> Joyce, Geoffrey et al. "Employer Drug Benefit Plans and Spending on Prescription Drugs." *JAMA* Volume 288, No. 14 (October 9, 2002).
- <sup>17</sup> Francis, Walton. *Testimony on reforming the FEHBP, before the Subcommittee on the Civil Service, Census, and Agency Reorganization*. Committee on Government Reform, U.S. House of Representatives, December 11, 2002. Online at [www.galen.org/news/Francistestimony.doc](http://www.galen.org/news/Francistestimony.doc).
- <sup>18</sup> Francis, Walton. *CHECKBOOK's Guide to Health Plans for Federal Employees*. Washington, DC. Washington Consumers Checkbook. 2002. Page 80. Retiree version with full text at [www.retireehealthplans.org](http://www.retireehealthplans.org)
- <sup>19</sup> Davis, *op cit*.
- <sup>20</sup> American Association of Health Plans. "Seniors Rally in Support of Medicare+Choice." Press release dated May 14, 2003. Online at [www.aahp.org](http://www.aahp.org).
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- <sup>22</sup> Jones, Nora Super. *Communicating to Beneficiaries about Medicare+Choice: Opportunities and Pitfalls*. Issue Brief, National Health Policy Forum. July 24, 1998. Online at [www.nhpf.org](http://www.nhpf.org).
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- <sup>24</sup> Carliner, David. "Getting the Elderly Their Due." *Health Affairs*, November/December 2002. Online at [www.healthaffairs.org](http://www.healthaffairs.org).
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- <sup>26</sup> Carliner, *op cit*.

<sup>27</sup> Francis, Walton. 2002 Testimony on reforming the FEHBP, before the Subcommittee on the Civil Service, Census, and Agency Reorganization, Committee on Government Reform, U.S. House of Representatives, *op cit*.

<sup>28</sup> Reischauer, Robert. "Medicare Reform and the Federal Employees Health Benefits Program", testimony before the Senate Committee on Finance, May 21, 1997. Online at [www.brook.edu/dybdocroot/views/testimony/reischauer/19970521.htm](http://www.brook.edu/dybdocroot/views/testimony/reischauer/19970521.htm).

<sup>29</sup> Francis, Walton. 2002 Testimony on reforming the FEHBP, before the Subcommittee on the Civil Service, Census, and Agency Reorganization, Committee on Government Reform, U.S. House of Representatives, *op cit*.

<sup>30</sup> Florence, Curtis and Ken Thorpe. "Marketwatch: How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection." *Health Affairs*, March/April 2003. Online at [www.healthaffairs.org](http://www.healthaffairs.org).

<sup>31</sup> Merlis 1999, *op cit*. Page 44.

<sup>32</sup> Gold, Marsha. "Can Managed Care and Competition Control Medicare Costs." *Health Affairs*, April 2003. Online at [www.healthaffairs.org](http://www.healthaffairs.org).

<sup>33</sup> Schmid, Stuart. "Geographic Variation in Medical Costs: Evidence from HMOs." *Health Affairs* 14 (1), Spring 1995.

<sup>34</sup> The legal authority cited by Medicare, title VI of the Civil Rights Act, has never been held to cover government contractors such as health plans, has never been held to require unreimbursed individual interpreters, and could not be held to require either without a regulatory impact analysis under Executive Order 12866 and the Regulatory Flexibility Act.

<sup>35</sup> Francis, Walton. "The Political Economy of the Federal Employees Health Benefits Program." *Health Policy Reform: Competition and Controls*, edited by Robert B. Helms. Washington DC. AEI Press. 1993.

<sup>36</sup> Francis, Walton. 2002 Testimony on reforming the FEHBP, before the Subcommittee on the Civil Service, Census, and Agency Reorganization, Committee on Government Reform, U.S. House of Representatives, *op cit*.

<sup>37</sup> Boccuti, Cristina and Marilyn Moon. 2003. "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades." *Health Affairs*, March/April 2003. Online at [www.healthaffairs.org](http://www.healthaffairs.org).

<sup>38</sup> Antos, Joseph and Alfredo Goyburu. 2003. "Comparing Medicare and Private Health Insurance Spending". Heritage Foundation Research paper, dated April 8, 2003. Online at [www.heritage.org](http://www.heritage.org).

<sup>39</sup> Pear, Robert. "Critics Say Proposal for Medicare Could Increase Costs." *New York Times*, May 6, 2003.

<sup>40</sup> Francis, Walton. 2002 Testimony on reforming the FEHBP, before the Subcommittee on the Civil Service, Census, and Agency Reorganization, Committee on Government Reform, U.S. House of Representatives, *op cit*.

<sup>41</sup> Reischauer, Robert. 1997. "Medicare Reform and the Federal Employees Health Benefits Program", testimony before the Senate Committee on Finance, May 21, 1997. Online at [www.brook.edu/dybdocroot/views/testimony/reischauer/19970521.htm](http://www.brook.edu/dybdocroot/views/testimony/reischauer/19970521.htm). See also Fox, Peter et al. "Should Medicare HMO Benefits Be Standardized," *Health Affairs*, Volume 18 (4), July/August 1999. Online at [www.healthaffairs.org](http://www.healthaffairs.org).

<sup>42</sup> Francis, Walton. "Key Issues in Medicare Reform." Testimony before the Committee on Ways and Means, Subcommittee on Health, U.S. House of Representatives. February 28, 2001.

<sup>43</sup> Reischauer, *op cit*.

#### RESPONSES TO QUESTIONS FROM SENATOR FRIST

*Question.* In her testimony, Dr. Moon states that "price competition only arises when products are very similar, so that consumers can compare prices." Yet, Mr. Francis notes in his testimony that flexibility in FEHBP has been a clear advantage for consumers. The competitive FEHBP—which provides much greater flexibility for private sector health plans to shape benefit packages in response to consumer pressure than the more rigid Medicare program, and to more rapidly cover breakthrough medical devices and prescription drugs—has done a very good job of using a competitive model to both improve quality and hold costs in check over time. In fact, Mr. Francis, you say in your written testimony that "FEHBP benefits have been superior to those of Medicare for decades. The 'defined benefit' [of Medicare] turns out to be no more than a guarantee for a second rate product."

Could you please comment, and respond to Dr. Moon's assertion?

*Answer.* In a modern market economy, it is rare for products sold to consumers to be identical. For example, there are literally hundreds of models of automobiles for sale, each varying in dozens and dozens of features and characteristics. Consumers Union and automobile magazines often compare cars on a dozen or more of

these characteristics, selected as just the most important. Yet no one would doubt that automobiles compete on price, or that consumers compare price. They compare price, quality, and features simultaneously. If they can compare automobiles on these complex variables, they can certainly compare health insurance policies, which are much simpler products. In the FEHBP, as in the automobile market, inferior products as judged by consumers lose market share over time, and in some cases withdraw from the market. It is precisely because the elderly have no effective choice other than the “one size fits all” Medicare program that it is able to survive with inferior benefits.

*Question.* Mr. Francis, Dr. Moon and other commentators have written analyses in the past few years indicating that Medicare has done a better job than private health insurance plans in reducing growth in the cost of health care and health coverage. In fact, Dr. Moon repeats some of that analysis in her testimony today (page 4). However, these analyses are either (1) misleading; or (2) not applicable to the proposed reforms to Medicare we are considering. The real comparison here is not between Medicare and private insurance costs, but between Medicare and other competitive public programs built on a model of public-private cooperation—such as FEHBP and the California Public Employee’s and Retiree’s Program (CalPERS).

In fact, the information that I have been able to review shows that over the past two decades (from 1984–2002), Medicare spending has grown at about the same, or somewhat faster, than FEHBP and CalPERS.

- Medicare: 7.0% per year
- FEHBP: 7.1% per year
- CalPERS: 6.5% per year

And, as we all know, Medicare does not cover drugs or other benefits typically covered by FEHBP and CalPERS. In fact, because Medicare has been insulated from consumer preferences (in favor of politicians’ and regulators’ preferences), the CalPERS and FEHBP benefits are typically much more generous. When drug spending is removed from the calculations, in fact, Medicare is somewhat LESS competitive with the two other programs.

- FEHBP without drugs: 6.8% per year
- CalPERS without drugs: 6.3% per year

Mr. Francis, your testimony supports this analysis, and also makes clear that FEHBP has ensured lower out of pocket costs and greater benefits over time. Can you comment?

*Answer.* I cannot agree more. There are different ways of comparing the programs, and no one has yet performed the “final word” comparison, but it simply cannot be disputed that FEHBP, without the benefit of government price controls, and with the disadvantage of paying for ever more costly prescription drugs, at least equals and probably exceeds Medicare’s cost control performance over time. In his testimony, Tom Scully gave several examples involving billions of dollars in Medicare spending due to the inflexibility and complications of trying to restrain costs through direct government price controls. The HHS Inspector General’s Office has long argued that waste in the Medicare program is in the tens of billions of dollars annually (these reports often use “fraud” in the title but the costliest examples involve waste, not fraud). Overpayments for drugs, excessive “outlier” hospital payments, and innumerable other examples of waste simply don’t occur in the FEHBP on anything like the Medicare scale, or anything like the time consuming legislative and regulatory processes necessary for Medicare to reform. It is because the FEHBP plans can avoid these and other problems through nimble, consumer friendly management, that the program so consistently outperforms Medicare.

*Question.* As a physician, choice of provider is critically important and must be ensured in any new program.

Mr. Francis, your testimony is striking to me in several respects. First, you point out that EVERY SINGLE federal employee in EVERY SINGLE area of the country has a choice of at least 12 private health plans and that almost all of these “private fee-for-service” or PPO plans have substantial choice of doctor. You also cite physician surveys showing that (in part because of unrealistically low reimbursement) “physicians are significantly LESS willing to accept Medicare patients than private plan patients.”

If the Medicare system changed gradually over time to look more like FEHBP, in your opinion would seniors have greater access to health providers of their choice?

You say that FEHBP provides “strong rural access.” How has FEHBP been able to assure stable, comprehensive, and relatively affordable private coverage for decades—even in rural areas of the country—while Medicare has failed?

*Answer.* Under a reformed Medicare offering a choice of plans, I think that some consumers would gain provider choice, some would retain roughly existing levels of

choice, and some—perhaps most—would voluntarily accept reduced choices in order to save premium and coinsurance costs. That would be a great tradeoff to offer seniors because there is no evidence to suggest that the widest possible choice is necessary either to assure access or to meet consumer needs for high quality physicians. Furthermore, even Medicare cannot provide the widest possible choice since many of the best physicians will not accept Medicare patients and the more that Medicare tries to restrain costs by reducing reimbursement, the worse this problem will be.

The FEHBP serves enrollees scattered throughout the United States (and even abroad), such as rural postal carriers and retirees. The plans serve these rural areas in two ways. First, they let their enrollees voluntarily go to any provider, but restrict reimbursement to a reasonable level so that the enrollee has to pay any excess cost. Second, they offer a better deal for using preferred providers who work with the plans to restrain cost growth. Savings accrue both from the volume discount that preferred providers get and from their attempts to curb unnecessary utilization. These approaches work just as well in rural areas as in urban areas, if not better. The plans have a strong marketing incentive to attract as many enrollees as possible, and need to maintain good national reputations. Furthermore, because rural areas on average have somewhat lower costs than urban areas, plans want to attract lower cost rural enrollees to keep overall costs and premiums down. For all these reasons, plans make sure that their rural networks are strong and consumer responsive.

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PREPARED STATEMENT OF HON. CHARLES E. GRASSLEY

Exploring ways to improve Medicare is a familiar activity for this committee. In fact, since 1999, the Finance Committee has held 29 hearings on Medicare, and seven of those have dealt specifically with Medicare prescription drugs. So we ask the question—why are we having yet another hearing on Medicare? Next week this committee will be doing something historic. We will be marking up legislation to create a prescription drug benefit within Medicare. Last year, the committee process was bypassed completely. We debated prescription drug legislation on the floor of the Senate without the due consideration of the Finance Committee. But this is a different year.

With an eye toward mark-up next week, several members requested today's hearing to further examine various policy options. Many look to the Federal Employees' Health Benefit Program as a model for Medicare. Federal employees all over the country, even in rural states like mine, have a choice of private health plans. Many of these plans are preferred provider organizations or PPOs. With the quality and innovation that PPOs offer, many believe the Medicare program could be strengthened and improved by developing such an option for Medicare beneficiaries.

The health policy experts we have here today will be able to shed some light on what these PPOs are all about, how they work, and how they could be used to deliver better health care for our seniors.

Our first witness will be Mr. Tom Scully, Administrator of the Centers for Medicare and Medicaid Services. He will be followed by our second panel which includes Mr. Walton Francis, an author and independent consultant, and Ms. Marilyn Moon from the Urban Institute. All three have been deeply involved in health policy analysis, research and administration for many years and we are fortunate they can join us today.

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PREPARED STATEMENT OF MARILYN MOON

Mr. Chairman and members of the Committee: Thank you for inviting me here today to testify on the important question of how to improve the Medicare program.

Normally when I provide testimony on Medicare I focus on the impacts on beneficiaries and how to improve the program so as to fairly meet its goals. And indeed, that will be a major focus of this written statement. However, I also feel compelled to begin with a number of comments that reflect my training as a traditional economist. I am concerned that in the name of "cost savings" and "efficiency," a number of changes in Medicare are being proposed that violate basic economic principles.

If competition is to be promoted and relied upon to generate greater efficiency, a number of conditions should be met. The success of any "competition-based" reform plan will depend on how the following issues are addressed.

First, **the playing field must be level.** How can we test whether private plans are a better deal for beneficiaries than traditional Medicare if the legislation pro-

vides extra subsidies or benefits to these private plans? If private plans are more efficient as claimed, then the best test is to let the market work.

Second, **price competition only arises when products are very similar so that consumers can compare prices.** If, in the case of prescription drugs, for example, the cost sharing structure and the formulary (i.e. what drugs will be covered under what conditions) vary, it will become very difficult for consumers to make good choices. In the case of preferred provider organizations, choices are even more difficult because of the broad range of ways in which coverage can vary. How does a consumer trade off hospital co-payments with varying drug benefits with limited access to providers, for example?

A third and related issue is that **reliable information is needed when plans vary in coverage and access to care.** But, at present, much of the information claiming that PPOs allow access to any doctor or hospital is misleading. Only in-network providers likely will be available at reasonable rates. A number of studies point out how limited some of the FEHBP networks can be. Further, even savvy consumers cannot find out what it will cost them to go out-of-network. These are details, but essential to making good choices.

Fourth, if we expect consumers to plan for their expenses and be good budgeters, **a drug plan that contains a “gap” or “donut hole” makes no sense.** If the government contribution is high for the first part of the year when a consumer is purchasing drugs, he or she is likely to come to expect that. But the dirty little secret of a gap is that, for a person with expenditures of, say, \$5000 per year, the plan would contribute to costs from February to September, but then stop paying any of the drug costs come October. There will be a lot of confused and angry consumers in line at their local pharmacies in the fall.

Fifth, **any plan reforming Medicare needs to contend with the potential for “market failure.”** When conditions, such as lack of knowledge by consumers, competitive advantages by some suppliers over others, incentives for risk selection that can be only poorly addressed, or the presence of social goals that the market is not designed to meet exist, don't expect markets to work well. The social goals will not be achieved, and there may be little efficiency or cost savings arising from the market.

As someone concerned about social goals, the rest of my testimony attempts to explain why I have concerns about the details that seem to be part of the proposal the Senate will be debating, and, on a broader scale, about the optimism that a private sector approach can make a serious dent in the issues facing Medicare now and in the future. Finally, on a practical level, more attention needs to be placed on improving the traditional program that now serves nearly nine out of every ten beneficiaries and will continue to have a disproportionate number of enrollees. Stoop loss protections and incentives for care coordination ought not be limited to PPOs.

Difficult challenges arise in deciding how to reform Medicare to meet future demands that an aging population and rising health care costs inevitably will place on the system. Costs to society for the health care of older and disabled Americans will rise over time, both in dollars and as a share of our economy. Market forces do not represent the magic bullet that will solve all of Medicare's problems. Nonetheless, much of the debate on Medicare's future has focused on broad restructuring proposals. This restructuring would rely upon contracting with private insurance plans, which would compete for enrollees. In addition, a drug benefit, representing an important promise made to beneficiaries, is also a critical part of the debate.

These changes could profoundly affect Medicare's future, but as yet there are few details on which to base an informed debate. I attempt to raise here a number of issues that ought to be carefully considered before making a massive change in this program. The second half of my testimony focuses on broader philosophical issues regarding changes in Medicare.

#### CONCERNS ABOUT THE DETAILS KNOWN SO FAR

The initial summary released about the Senate Finance plan indicates that a number of improvements have been made over the earlier approach outlined by the Administration. Providing the same actuarially equivalent drug benefits to all Medicare beneficiaries regardless of what plan they choose is a major advance in fairness. And the low income protections have been expanded over what has been proposed in the past. Nonetheless, a number of elements remain troublesome. The following is a list of such issues, not intended to be exhaustive, but rather illustrative of the care that is needed before putting together any final legislation. Each of these issues ought to be discussed at considerable length and supplemented with details not available at this time.



- **Low income beneficiaries.** Treating low income Medicare beneficiaries who are also participating in the Medicaid program exclusively through the means-tested Medicaid program would make them “second class citizens.” One of Medicare’s enormous strengths is its universal treatment. The 17 percent of beneficiaries who are dually eligible should be at the top of the list of concerns for reform and not shunted to the bottom.
- **Who is considered in need of special help.** While the suggested drug benefit offers substantially better drug benefit for those who it would cover, the level of income necessary to obtain protection is very low. At 150 percent of poverty, a drug cost of even \$2000 can be catastrophic. But that is where this plan’s help for those with low income would end. As Table 1 indicates, drug costs for someone with modest incomes but above the protected level would quickly become exorbitant even if that person bought into the drug benefit.
- **The “gap” or “donut hole” in the drug benefit** generates major problems. It is hard to understand and reduces protection just at the time when many of those who are most in need are expecting some relief. That is, persons with chronic conditions are likely to have drug expenses in the range of \$3,000 to \$5,000. Many take several drugs every day, each of which can cost \$1,000 or more per year. This is where the growth in spending is occurring and it is these drugs that may ultimately help to lower health care costs in the future. From the early numbers released on the benefit’s structure, persons with spending between \$5,000 and \$5,500 would have to pay over two thirds of the costs of their drugs. This is a greater share than someone with \$2000 in expenditures has to pay, for example. A flat percentage contribution up to a catastrophic limit would be a fairer, simpler, and more honest way to structure a benefit. The basic problem is that \$400 billion is not enough to provide a well-designed prescription drug benefit.
- **Disadvantages of a standalone drug benefit.** Beneficiaries in traditional Medicare will be put at a particular disadvantage by the having to purchase a standalone drug benefit. For a number of reasons, separating that benefit from the rest of Medicare will make it a less efficient and hence more costly benefit. If the actuarial value is the same as that for integrated plans, traditional Medicare beneficiaries may be put at a disadvantage since more of the costs will go to administration than if it were coordinated with Medicare. And if plans are allowed to tinker with the deductibles, the formularies and other aspects of the benefit, it will be very difficult for beneficiaries to know what they are getting.
- **The Fallback Drug Benefit.** The convoluted means for assuring a drug benefit to those in traditional Medicare means that individuals cannot count on a stable and viable benefit over time. If they must change plans frequently and occasionally rely on a fallback system, beneficiaries may find themselves having to shift drugs as the formularies and other details of plans change. More stability is needed. Why not simply offer a fallback benefit through Medicare as a standard option available to everyone? If private plans prove themselves, then beneficiaries may not use the government option. If private plans cannot compete effectively, why should special efforts be made to prop them up?
- **Subsidies to private plans.** Finally, why offer a 2 percent increase in payments to PPOs? Let private plans prove themselves as markets are meant to do without special treatment for one player or another. If any special treatment is to be given, it ought to be directed where the most vulnerable beneficiaries choose to enroll. For the foreseeable future, that is likely to be traditional Medicare. And this is particularly troublesome in an environment where the drug benefit is poorly designed because of the limits on what the Congress is willing to spend. A 2 percent payment add-on for PPOs, for example, would amount to an extra \$153 per enrollee in 2006. And if 20 percent of Medicare beneficiaries move to such plans, that will require a commitment of resources sufficient to otherwise reduce the monthly premium for all beneficiaries for a drug benefit by \$5 per month, for example.

#### MEDICARE VS. THE PRIVATE SECTOR

Looking back over the period from 1970 to 2000, Medicare’s cost-containment performance has been better than that of private insurance. Starting in the 1970s, Medicare and private insurance plans initially grew very much in tandem, showing few discernible differences. By the 1980s, per capita spending had more than doubled in both sectors for comparable services. But Medicare became more cost-conscious than private health insurance in the 1980s, and cost containment efforts, particularly through hospital payment reforms, began to pay off. From about 1984 through 1988, Medicare’s per capita costs grew much more slowly than those in the

private sector. Thus, its base relative to the private sector contracted and a gap in the two growth lines shown in Figure 1 opened up.

This gap in overall growth in Medicare's favor stayed relatively constant until the mid 1990s when private insurers began to take seriously the rising costs of health insurance. At that time, growth in the cost of private insurance moderated in a fashion similar to Medicare's slower growth in the 1980s. Thus, it can be argued that the private sector was playing "catch up" to Medicare in achieving cost containment. Private insurance narrowed the difference with Medicare in the 1990s, but as of 2000, there was still a considerable way for the private sector to go before its cost growth would match Medicare's achievement of lower overall growth.

Moreover, since 1988, information on private insurance indicates substantial increases in costs being passed on to consumers. Premiums charged to employees for policies, for example, have risen twice as fast as premiums in Medicare. Deductibles and other cost sharing have also risen rapidly over time in the private insurance market.

#### WILL RELYING ON PRIVATE PLANS INHERENTLY LEAD TO SAVINGS FOR MEDICARE?

Some supporters of a private approach seem to assume that private plans inherently offer advantages that traditional Medicare cannot achieve. But there is no magic bullet to holding the line on the growth in health care spending. Per capita spending rises because of the growth in use of services, higher prices, or a combination of the two. Medicare's price clout is well known and documented.

So what about use of services? Studies of managed care have concluded that most of them saved money by obtaining price discounts for services and not by changing the practice of health care. Reining in use of services represents a major challenge for private insurance as well as Medicare in the future, and it is not clear whether the public or private sector is better equipped to do this. The newest type of plans suggested as an improvement for Medicare beneficiaries, preferred provider organizations (PPOs), generally obtain their savings by paying very little for any patient who goes outside the network to get care. Thus, their strategy is often one of cost shifting onto beneficiaries. This may hold down PPO premiums, but from society's standpoint, does little to help with reducing health care costs.

Private insurers are interested in satisfying their own customers and generating profits for stockholders. When the financial incentives they face are very broad (such as receiving capitated payments), private insurers respond as good business entities should. They seek the easiest ways of holding down costs in the provision of services. This indeed is what competition is all about. Cream skimming of the market serves these goals very well: Medicare overpays, and plans can both make the healthier beneficiaries they enroll very satisfied while making good profits. The problem is that this response is not good for limiting overall costs to either the federal government or to society as a whole. Thus, care needs to be taken to use the market when we understand and approve of the direction that competition will take health care delivery.

In addition, private insurers will almost surely have higher administrative overhead costs than does Medicare. Insurers need to advertise and promote their plans. They would face a smaller risk pool that may require them to make more conservative decisions regarding reserves and other protections against losses over time. These plans expect to return a profit to shareholders. All of these factors cumulate and work against private companies performing better than Medicare.

Finally, it is important to note that few private insurance companies escape problems of complexity and bureaucracy. Many patients, both young and old, find the requirements of their plans to obtain approval before getting some services, to determine which doctors and hospitals are in network and which are not, to understand the bills when they come due months later, and to use the appeals process to be cumbersome, complex and overly bureaucratic. Thus, problems with the complexity of our current health care system are by no means inherent only to government. So examining reform from the context of Medicare beneficiaries should consider whether more reliance on private plans will only complicate and confuse beneficiaries further. An assumption is often made that using private plans to provide services will ease the government's oversight burdens, but at what expense to beneficiaries?

#### USING COMPETITION TO GENERATE SAVINGS

Reform options such as the premium support approach seek savings not only by relying on private plans but also on competition among those plans. Often this includes allowing the premiums paid by beneficiaries to vary such that those choosing higher cost plans pay substantially higher premiums. The theory is that bene-

ficiaries will become more price conscious and choose lower cost plans. This in turn will reward those private insurers able to hold down costs. And there is some evidence from the federal employees system and the CalPERS system in California that this has disciplined the insurance market to some degree in the 1990s. But the experiences in the last few years lend considerable doubt to that enthusiasm.

Studies that have focused on retirees, moreover, show much less sensitivity to price differences among older Americans. Older persons may be less willing to change doctors and learn new insurance rules in order to save a few dollars each month. Thus, what is not known is how well this will work for Medicare beneficiaries.

For example, for a competitive approach to work, at least some beneficiaries must be willing to shift plans each year (and to change providers and learn new rules) in order to reward the more efficient plans. Without that shifting, savings will not occur. In addition, there is the question of how private insurers will respond. (If new enrollees go into such plans each year, some savings will be achieved, but these are the least costly beneficiaries, and may lead to further problems as discussed below.) Will they seek to improve service or instead focus on marketing and other techniques to attract a desirable, healthy patient base? It simply isn't known if the competition will really do what it is supposed to do. In fact, undesirable outcomes may be as common as desirable ones.

New approaches to the delivery of health care under Medicare may generate a whole new set of problems, including problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients; it is not only disruptive, it can raise costs of care. Studies have shown that having one physician over a long period of time reduces costs of care. And if it is only the healthier beneficiaries who choose to switch plans, the sickest and most vulnerable beneficiaries may end up being concentrated in plans that become increasingly expensive over time. The case of retirees left in the federal employees high-option Blue Cross plan and in a study of retirees in California suggest that even when plans become very expensive, beneficiaries may be fearful of switching and end up substantially disadvantaged.

Private plans should not be expected to meet larger social goals such as making sure that the sickest beneficiaries get high quality care if the financial incentives do not lead to such behavior. To the extent that such goals remain important, reforms in Medicare will have to incorporate additional protections to balance these concerns as described below.

#### WHAT IT IS CRUCIAL TO RETAIN FROM MEDICARE

The reason to "save" Medicare is to retain for future generations the qualities of the program that are valued by Americans and that have served them well over the past 37 years. This means that any reform proposal ought to be judged on principles that go well beyond the savings that they might generate for the federal government.

I stress three crucial principles that are integrally related to Medicare's role as a social insurance program:

- The universal nature of the program and its consequent redistributive function.
- The pooling of risks that Medicare has achieved to share the burdens across sick and healthy.
- The role of government in protecting the rights of beneficiaries—often referred to as its entitlement nature.

Although there are clearly other goals for and contributions of Medicare, these three are part of its essential core. Traditional Medicare, designed as a social insurance program, has done well in meeting these goals. What about options relying more on the private sector?

#### *Universality and Redistribution*

An essential characteristic of social insurance that Americans have long accepted is the sense that once the criterion for eligibility of contributing to the program has been met, that benefits will be available to all beneficiaries. One of Medicare's great strengths has been providing much improved access to health care. Before Medicare's passage, many elderly persons could not afford insurance, and others who could not obtain it were denied coverage as poor risks. That changed in 1966 and had a profound impact on the lives of millions of seniors. The desegregation of many hospitals occurred under Medicare's watch. And although there is substantial variation in the ability of beneficiaries to supplement Medicare's basic benefits, basic care is available to all who carry a Medicare card. Hospitals, physicians, and other providers largely accept the card without question.

Once on Medicare, enrollees no longer have to fear that illness or high medical expenses could lead to the loss of coverage—a problem that still happens too often in the private sector. This assurance is an extremely important benefit to many older Americans and persons with disabilities. Developing a major health problem is not grounds for losing the card; in fact, in the case of the disabled, it is grounds for coverage. This is vastly different than the philosophy of the private sector towards health coverage. Even though many private insurers are willing and able to care for Medicare patients, the easiest way to stay in business as an insurer is to seek out the healthy and avoid the sick. And in a market system, once that becomes the dominant approach, even insurers who would like to treat sicker patients are penalized by the market if they do so. This can clearly be seen in the poor performance of the individual health insurance market in meeting the needs of persons in their early 60s.

Will reforms that lead to a greater reliance on the market still retain the emphasis on equal access to care and plans? For example, differential premiums could undermine some of the redistributive nature of the program that assures even low-income beneficiaries access to high quality care and responsive providers. Support for a market approach that moves away from a “one-size-fits-all” approach is a prescription for risk selection problems.

Perhaps of greatest concern is whether the dual eligibles who receive both Medicare and Medicaid continue to be treated as full Medicare beneficiaries. If, as some documents have indicated, the primary responsibility for these individuals will fall to Medicaid, the principle of universality will be undermined, and the most vulnerable seniors and persons with disabilities will be disenfranchised. States vary in their generosity and interest in this population. Further, people move in and out of Medicaid over time. How would they be treated by Medicare in those instances?

#### *The Pooling Of Risks*

One of Medicare's important features is the achievement of a pooling of risks among the healthy and sick covered by the program. Even among the oldest of beneficiaries, there is a broad continuum across individuals' needs for care. Although some of this distribution is totally unpredictable (because even people who have historically had few health problems can be stricken with catastrophic health expenses), a large portion of seniors and disabled persons have chronic problems known to be costly to treat. If these individuals can be identified and segregated, the costs of their care can expand beyond the ability of even well-off individuals to pay over time.

A major impetus for Medicare was the need to protect the most vulnerable. That's why the program focused exclusively on the old in 1965 and then added the disabled in 1972. About one in every three Medicare beneficiaries has severe mental or physical health problems. In contrast, the healthy and relatively well-off (with incomes over \$32,000 per year for singles and \$40,000 per year for couples) make up less than 10 percent of the Medicare population. Consequently, anything that puts the sickest at greater risk relative to the healthy is out of sync with this basic tenet of Medicare. A key test of any reform should be who it best serves.

If the advantages of one large risk pool (such as the traditional Medicare program) are eliminated, other means will have to be found to make sure that insurers cannot find ways to serve only the healthy population. Although this very difficult challenge has been studied extensively; as yet no satisfactory risk adjustor has been developed. What has been developed to a finer degree, however, are marketing tools and mechanisms to select risks. High-quality plans that attract people with extensive health care needs are likely to be more expensive than plans that focus on serving the relatively healthy. If risk adjustors are never powerful enough to eliminate these distinctions and level the playing field, then those with health problems, who also disproportionately have lower incomes, would have to pay the highest prices under many reform schemes.

On the other hand, it does not seem to be wise policy in a period of resource scarcity to pay private plans more than is available to traditional Medicare to participate. Some outlier payment or risk adjustment might be used to help encourage plans to come into the program, but a flat, across-the-board payment addition is unsound policy and unfair to those remaining in traditional Medicare.

#### *The Role of Government*

Related to the two above principles is the role that government has played in protecting beneficiaries. In traditional Medicare, this has meant having rules that apply consistently to individuals and assure that everyone in the program access to care. It has sometimes fallen short in terms of the variations that occur around the country in benefits, in part because of interpretation of coverage decisions but also

because of differences in the practice of medicine. For example, rates of hospitalization, frequency of operations such as hysterectomies, and access to new tests and procedures vary widely by residence, race and other characteristics. But in general, Medicare has to meet substantial standards and accountability that protect its beneficiaries.

If the day-to-day provision of care is left to the oversight of private insurers, what will be the impact on beneficiaries? It is not clear whether the government will be able to provide sufficient oversight to protect beneficiaries and assure them of access to high-quality care. If an independent board—which is part of many restructuring proposals—is established to negotiate with plans and oversee their performance, to whom will it be accountable? Further, what provisions will be in place to step in when plans fail to meet requirements or who leave an area abruptly? What recourse will patients have when they are denied care? The need for this oversight will likely add to administrative costs; if not, beneficiaries will suffer. At present Medicare pays only 30 cents per beneficiary annually for the state counseling programs to answer questions from beneficiaries. That already inadequate budget needs to be expanded by a factor of ten or more in the type of environment anticipated.

#### ASSESSING THE PROMISED ADVANTAGES OF PRIVATE SECTOR APPROACHES

A number of advantages in addition to holding the line on costs are also often put forth to generate support for this type of approach. A private approach has the potential to reduce the role in government of “micromanaging” health care, often expressed as no more price fixing by government and greater flexibility for innovation and change in coverage of benefits. But even more frequently, this approach is emphasized as a means for moving away from a “one size fits all” approach to insurance. In practice, however, some of these claims are likely to interfere with the functioning of effective competition aimed at holding down the costs of care. Tradeoffs will undoubtedly need to be made.

#### *Choice*

While choice and avoidance of uniformity is an appealing promise, it is important to examine exactly what that means. Many people have made the point that most beneficiaries want choice of providers of care—doctors and hospitals. They care much less about whether it is Aetna or Cigna that provides the insurance. (Actually, that may turn out to be quite shortsighted if plans vary in terms of the details of operations, such as how much they will pay for services when someone goes out of network. But those considerations are hard to build into a choice model since even aggressive consumers find it difficult to obtain such information.)

But the appeal for choice of plan is usually made on the argument that people will be able to get only the coverage they want and need, even if they have to pay a little more. The difficulty is that without standardization of the most important benefits, such choice will lead to risk selection. Young healthy 65 year olds will pass on home health coverage, for example, in exchange for other benefits or a lower premium. But until risk adjusters get much better (if ever), standardization is important. Moreover, to get plans to compete on price, consumers must be able to compare plans—another strong argument for standardization. It is not possible to realistically expect both variation in options and health competition.

#### *Flexibility, Innovation and Oversight*

One of the advantages touted for private plans is their ability to be flexible and even arbitrary in making decisions. This allows private insurers to respond more quickly than a large government program can and to intervene where insurers believe too much care is being delivered. But what looks like cost-effectiveness activities from an insurer’s perspective may be seen by a beneficiary as the loss of potentially essential care. Which is more alarming: too much care or care denied that cannot be corrected later? Some of the “inefficiencies” in the health care system may be viewed as a reasonable response to uncertainty when the costs of doing too little can be very high indeed. This arbitrariness also means that providers can be dropped from a plan with little notice, potentially adding to disruptions for beneficiaries.

The need for strong government oversight will not go away under a private plan approach unless there are to be few beneficiary protections. Many insurers do not have a good track record in this area, for example. Patient problems and complaints under the Medicare+Choice option underscore the need to offer appeals rights, oversight and sometimes direct intervention in order to protect beneficiaries. For example, at present when plans are found to be inappropriately denying care to beneficiaries, the corrections are done on a case-by-case basis even after the same plan in the same area has been told multiple times to cover a particular service. If pri-

vate plans are to be even more widespread, this will require a great deal of attention and effort.

Considerable investment in information and education would be needed—spending that goes well beyond what Congress has been willing to commit thus far. Information about plans should not be left solely to the responsibility of the plans themselves.

Unfortunately, there are too few examples of truly innovative new techniques, organizational strategies or other contributions from private plan competition. Many managed care plans, for example, have relied on price discounts and do not even have the data and administrative mechanisms to attempt any care coordination. And preferred provider organizations—the newest private form to be hailed as an improvement—rely not only on price discounts but on passing off very high costs to beneficiaries who choose to go out of network for their care. Here the misconception is that you can see any care provider you wish. That's true for those with substantial resources but not for the vast majority of Medicare beneficiaries who have only modest incomes. And as the recent CMS report suggests, the main mechanism PPOs have to control use of services is to drop providers deemed to be ordering too many services. At best, this is a crude adjustment device.

If innovation is a major reason for relying on private plans, it may make most sense to provide incentives for plans to specialize and take on those with high risks or particular conditions. This is where innovation is needed and where care coordination potentially offers the greatest payoffs.

#### *Avoiding Price Setting*

Moving away from traditional Medicare will not eliminate the issue of administered prices in health care. There is no free market where doctors and plans negotiate openly on rates. In fact, many private plans use at least some aspect of Medicare payment systems in setting their rates. In a world of many private insurers, the likely result is hundreds of administered prices being set for each service by each plan.

In an industry like health care where there are many examples of “market failure” (because of concentrated power, lack of good information and knowledge, product differentiation), the workings of supply and demand can lead to perverse results. For example, competing hospitals in a given area result in over-capacity as each hospital tries to have all the latest equipment to attract doctors and patients. As already mentioned, plans will tend to compete to attract healthy patients rather than to develop the best management and care coordination protocols. And yes, price setting is and will continue to be a part of the private insurance world as well as within Medicare.

#### CHANGES TO IMPROVE MEDICARE

Making changes to Medicare that can improve its viability both in terms of its costs and in how well it serves older and disabled beneficiaries should certainly be pursued. Further, it makes little sense to look for a solution that takes policy makers permanently out of Medicare's future. The flux and complexity of our healthcare system will necessitate continuing attention to this program. At present a number of areas in Medicare need attention. No reform plan can be considered adequate if it ignores traditional Medicare.

What are the tradeoffs from increasingly relying on private plans to serve Medicare beneficiaries? The modest gains in lower costs that are likely to come from some increased competition and from the flexibility that the private sector enjoys could be more than offset by the loss of social insurance protection. The effort necessary to create in a private plan environment all the protections needed to compensate for moving away from traditional Medicare will be very challenging and cannot promise success. For example, even after six years, many of the provisions in the Balanced Budget Act of 1997 that would be essential in any further moves to emphasize private insurance—generating new ways of paying private plans, improving risk adjustment, and developing information for beneficiaries, for example—still need a lot of work.

In addition, it is not clear that there is a full appreciation by policymakers or the public at large of all the consequences of a competitive market. Choice among competing plans and the discipline that such competition can bring to prices and innovation are often stressed as potential advantages of relying on private plans for serving the Medicare population. But if there is to be choice and competition, some plans will not do well in a particular market, and as a result they will leave. In fact, if no plans ever left, that would likely be a sign that competition was not working well. But plan withdrawals will result in disruptions and complaints by beneficiaries—much like those that have occurred with the withdrawals from

Medicare+Choice. Beneficiaries must then find another private plan or return to traditional Medicare. They may have to choose new doctors and learn new rules. This situation has led to politically charged discussions about payment levels in the program even though that is only one of many factors that may cause plans to withdraw. Thus, not only will beneficiaries be unhappy, but there may be strong political pressure to keep federal payments higher than a well functioning market would require.

What I would prefer to see instead is emphasis on improvements in *both* the private plan options and the traditional Medicare program, basically retaining the current structure in which traditional Medicare is the primary option. Rather than focusing on restructuring Medicare to emphasize private insurance, I would place the emphasis on innovations necessary for improvements in health care delivery regardless of setting.

Critics of Medicare rightly point out that the inadequacy of its benefit package has led to the development of a variety of supplemental insurance arrangements which in turn create an inefficient system in which most beneficiaries rely on two sources of insurance to meet their needs. It is sometimes argued that improvements in coverage can only occur in combination with structural reform. And some advocates of a private approach to insurance go further, suggesting that the structural reform itself will naturally produce such benefit improvements. This implicitly holds the debate on improved benefits hostage to accepting other unrelated changes. That logic actually should run in the other direction. It is not reasonable to expect any number of other changes to work without first offering a more comprehensive benefit package for Medicare. In that way, payments made to private plans can improve, allowing them to better coordinate care. And the fee for service system will also be able to change in ways that might encourage better care delivery. For example, it is not reasonable to ask patients to participate in a program to reduce hypertension (which can save costs over the long run) without covering the prescription drugs that are likely to be an essential part of that effort. In addition, a better benefit package will also allow at least some beneficiaries to forego the purchase of inefficient private supplemental insurance. That itself should be a goal of reform.

In addition, better norms and standards of care are needed if we are to provide quality of care protections to all Americans. Investment in outcomes research, disease management and other techniques that could lead to improvements in treatment of patients will require a substantial public commitment. This cannot be done as well in a proprietary, for-profit environment where dissemination of new ways of coordinating care may not be shared.

Private plans can play an important role and may develop some innovations on their own, but in much the same way that we view basic research on medicine as requiring a public component, innovations in health delivery also need such support. Further, innovations in treatment and coordination of care should focus on those with substantial health problems—exactly the population that many private plans seek to avoid. Some private plans might be willing to specialize in individuals with specific needs, but this is not going to happen if the environment is one emphasizing price competition and with barely adequate risk adjusters. Innovative plans would likely suffer in that environment. This is where I recommend work to enhance the effectiveness of private plans. Further, Finally, the default plan—where those who do not or cannot choose or who find a hostile environment in the world of competition—must, at least for the time being, be traditional Medicare. Thus, there needs to be a strong commitment to maintaining a traditional Medicare program while seeking to define the appropriate role for alternative options.

A good area to begin improvements in knowledge about the effectiveness of medical care would be with prescription drugs. Realistically, any prescription drug benefit will require efforts to hold down costs over time. Part of that effort needs to be based on evidence of the comparative effectiveness of various drugs, for example. Establishing rules for coverage of drugs should reflect good medical evidence and not just on which manufacturer offers the best discounts. Undertaking these studies and evaluations represents a public good and needs to be funded on that basis.

Within the fee-for-service environment, it would be helpful to energize both patients and physicians in helping to coordinate care. Patients need information and support as well as incentives to become involved. Many caring physicians, who have often resented the low pay in fee for service and the lack of control in managed care, would likely welcome the ability to spend more time with their patients. One simple way to do this would be to give beneficiaries a certificate that spells out the care consultation benefits to which they are entitled and allow them to designate a physician who will provide those services. In that way, both the patient and the physician (who would get an additional payment for the annual or biannual services) would know what they are expected to provide and could likely reduce confusion and un-

necessary duplication of services that go on in a fee for service environment. This change should be just one of many in seeking to improve care coordination.

Additional flexibility to CMS to manage and develop payment initiatives aimed at using competition where appropriate also could result in long term cost savings and serve patients well. In the areas of durable medical equipment and perhaps even some testing and laboratory services, contracting could be used to obtain favorable prices.

These are only a few examples of changes, none of which promise to be the magic bullet, but which could aid the Medicare program over time.

**Table 1**  
**Impact of Potential Prescription Drug Bill on Beneficiary Spending**

Income as a Share of Poverty	Total Drug Spending			
	\$1,000	\$4,000	\$6,000	\$10,000
140%				
<i>Beneficiary Share</i>	\$520	\$875	\$1,205	\$1,605
<i>Share of Income</i>	3.9%	6.6%	9.1%	12.1%
175%				
<i>Beneficiary Share</i>	\$1,058	\$2,833	\$4,203	\$4,603
<i>Share of Income</i>	6.4%	17.1%	25.4%	27.8%
400%				
<i>Beneficiary Share</i>	\$1,058	\$2,833	\$4,203	\$4,603
<i>Share of Income</i>	2.8%	7.5%	11.1%	12.2%

Source: Urban Institute analysis

#### RESPONSES TO QUESTIONS FROM SENATOR GRASSLEY

*Question.* In her testimony, Dr. Moon states that “price competition only arises when products are very similar, so that consumers can compare prices.” Yet, Mr. Francis notes in his testimony that flexibility in FEHBP has been a clear advantage for consumers. The competitive FEHBP—which provides much greater flexibility for private sector health plans to shape benefit packages in response to consumer pressure than the more rigid Medicare program, and to more rapidly cover breakthrough medical devices and prescription drugs—has done a very good job of using a competitive model to both improve quality and hold costs in check over time. In fact, Mr. Francis, you say in your written testimony that “FEHBP benefits have been superior to those of Medicare for decades. The ‘defined benefit’ [of Medicare] turns out to be no more than a guarantee for a second rate product.”

Could you please comment, and respond to Mr. Francis’s assertion?

*Answer.* It is important to separate the issue of the generosity of the benefit package and whether there is viable price competition across plans. When consumers cannot readily compare benefits and evaluate their differences, they may not reward the lowest price or most efficient plans by switching to them. They may choose instead on other bases. Since choice and competition is presented as a way to substantially hold down costs, it is important to decide how best to achieve that goal. My point is that allowing a lot of differences in benefits is incompatible with that goal. The FEHBP benefits are superior to those in Medicare because the Congress has explicitly chosen not to expand the Medicare benefit package. To determine whether FEHBP has been able to expand benefits at a low cost would require it to be examined explicitly during times in which the benefits were broadened. One would have



to go back further in time than most analyses have done to determine this. Moreover, in the last few years, beneficiaries have been asked to pay more cost sharing in FEHBP while it has remained more stable in Medicare. That would need to be factored in as well.

*Question.* Mr. Francis, Dr. Moon and other commentators have written analyses in the past few years indicating that Medicare has done a better job than private health insurance plans in reducing growth in the cost of health care and health coverage. In fact, Dr. Moon repeats some of that analysis in her testimony today (page 4). However, these analyses are either (1) misleading; or (2) not applicable to the proposed reforms to Medicare we are considering. The real comparison here is not between Medicare and private insurance costs, but between Medicare and other competitive public programs built on a model of public-private cooperation—such as FEHBP and the California Public Employee’s and Retiree’s Program (CalPERS).

In fact, the information that I have been able to review shows that over the past two decades (from 1984–2002), Medicare spending has grown at about the same, or somewhat faster, than FEHBP and CalPERS.

- Medicare: 7.0% per year
- FEHBP: 7.1% per year
- CalPERS: 6.5% per year

And, as we all know, Medicare does not cover drugs or other benefits typically covered by FEHBP and CalPERS. In fact, because Medicare has been insulated from consumer preferences (in favor of politicians’ and regulators’ preferences), the CalPERS and FEHBP benefits are typically much more generous. When drug spending is removed from the calculations, in fact, Medicare is somewhat LESS competitive with the two other programs.

- FEHBP without drugs: 6.8% per year
- CalPERS: 6.5% per year

Dr. Moon, your testimony supports this analysis, and also makes clear that FEHBP has ensured lower out of pocket costs and greater benefits over time. Can you comment?

*Answer.* The benefit packages in FEHBP and CalPERS have not become substantially more generous over this period. They have long included more than Medicare does. Thus, growth rates don’t tell us much at this point. Also, the emphasis on managed care and now the increase in consumer cost sharing represent deterioration in the FEHBP and CalPERS benefit packages over time.

In earlier work I have undertaken on Medicare, I note that adoption of new technology and the aging of the population should, all other things held constant, cause Medicare to grow faster than insurance for younger persons. My conclusion is that it is difficult to find convincing evidence that Medicare is substantially less efficient than these other approaches and that we should not overstate what savings are possible.

*Question.* As a physician, choice of provider is critically important and must be ensured in any new program.

If the Medicare system changed gradually over time to work more like FEHBP, in your opinion, would seniors have greater access to health providers of their choice?

You say that FEHBP provides “strong rural access.” How has FEHBP been able to assure stable, comprehensive, and relatively affordable private coverage for decades—even in rural areas of the country—while Medicare has failed?

*Answer.* It is important to consider in-network vs. out-of-network choices to be able to understand what is likely to be available to people in rural areas over time. Again, I believe that it is worth trying a PPO approach, but not at the expense of the traditional Medicare program which has provided itself for this vulnerable population.

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PREPARED STATEMENT OF HON. THOMAS A. SCULLY

Chairman Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me to discuss strengthening and improving the Medicare program. President Bush believes Medicare is the binding commitment of our society to our most vulnerable citizens and that this commitment to the American people should be kept. To this end, the President is urging Congress to provide more choices and better benefits to Medicare beneficiaries bringing Medicare into the 21st Century. In strengthening and improving what is now a \$277 billion program, we need to combine what we know are the strengths of the Medicare program with the best of the current private health insurance market and the Federal government’s experience in running the largest employer-sponsored health insurance program. As suc-

cessful as the Medicare program has been, it has not kept pace with decades of dramatic improvements in health care. As a result, Medicare beneficiaries today lack many of the options and benefit coverage available to millions of other Americans.

When it was created in 1965, Medicare was modeled after the Blue Cross and Blue Shield coverage existing at that time when health care didn't offer preventive care or catastrophic care and usually did not include a prescription drug benefit. Times and Blue Cross plans have changed, but Medicare has not changed with them. Not only must Medicare include the benefits we have all come to expect, but we should give Medicare beneficiaries the same options that Americans under age 65 enjoy. If we were creating the Medicare program today, we would model it after what consumers are receiving in today's health care marketplace: more choices and better benefits. Enrollees can now receive care at reduced cost from networks of preferred providers and obtain prescription drug coverage.

Medicare, as a national program with payment practices and provider participation rules determined mainly by statute, does not negotiate rates, but fixes prices to all providers, regardless of price, volume, or quality. Whether, and on what basis to treat providers differently is a complicated issue that often requires an intimate knowledge of local market conditions. A national program cannot make these local market-level distinctions, which is another reason Medicare needs improvement.

The opportunity to make these changes to strengthen and improve Medicare is now. With health care costs rising and the Baby Boom generation nearing retirement, Medicare faces serious long-term financial challenges. According to the most recent Medicare Trustees report, the cost of care continues to increase. For example, Medicare expenditures for inpatient hospital care increased by almost 10 percent in 2002 and Medicare Part B spending increased by over 9 percent; home health went up about 8 percent. Not only is it important to offer modern, innovative health care choices for seniors, but to do so in a way that is fiscally responsible.

We must update the program's structure to make the best use of our modern health care delivery methods to maximize the benefits for current and future participants including access to prescription drug coverage. The President has committed up to \$400 billion over the next ten years in his FY 2004 budget to pay for strengthening and improving Medicare, and has offered a framework that will give *all* Medicare beneficiaries access to:

- **Prescription drug coverage** that enables seniors and people with disabilities to get the medicines they need;
- **More choices of more health care plans**—just like Members of Congress and other federal employees enjoy today through the FEHBP;
- **Continued choice of doctors and hospitals** for the treatment and care they need;
- **No cost-sharing for preventive services** such as screenings for cancer, diabetes and osteoporosis; and,
- **Protection from high out-of-pocket costs**—Often available in plans, but not available to Medicare beneficiaries.

#### THE IMPACT OF PPOS

One option that achieves these principles are Preferred Provider Organizations (PPOs). PPOs are a growing form of health insurance and are now the most popular type of coverage in the private insurance market, covering 52 percent of the employer group market today. Together with the very similar Point of Service (POS) model that covers 18 percent of enrollees, 70 percent of insured Americans are in these "hybrid" plans. In contrast, traditional fee-for-service (FFS) plans represent only 5 percent of the private insurance market; however 87 percent of Medicare enrollees are in traditional FFS.

PPOs give beneficiaries a wide choice of providers, allowing them to stay within the PPO network for maximum cost savings or go outside the network to any doctor or hospital, if they desire. Moreover, they may include greater coverage of preventive care services as well as better coordination of health care services. Additionally, the PPO design is flexible enough to work well in both cities and rural areas. In particular, the vast majority of hospitals operating in rural counties—including counties where there is only one hospital—have Blue Cross contracts that are almost always part of a PPO, according to a May 2003 report by CMS' actuary.

Applying the principles outlined in the President's Framework, CMS' actuaries estimated that the average cost in competitive private plans, including PPOs, would be less over the 10-year period than the corresponding cost in traditional Medicare. These savings are expected to grow over time, primarily because beneficiaries enrolling in PPOs would have the option to switch to less expensive plans to reduce their

monthly premiums, and because the cost growth rates for PPOs are expected to be slightly less, on average, than increases in Medicare fee-for-service costs.

Our actuaries' estimate was derived from data that PPOs provided regarding CMS' PPO demonstration. These data suggest that the most efficient plans have the potential to deliver the same benefits for an average of 2.3 percent less than the cost of fee-for-service Medicare. PPO-style health plans have the potential to control costs as well as or slightly better than traditional Medicare over time; however, any potential savings or costs strongly depend on the proposal itself. For example, the potential for savings in Medicare depends greatly on whether:

- Beneficiaries are given the option to choose the most efficient plans and save money on their premiums;
- The bidding process accepts only a limited number of PPOs per region, so that plans bid aggressively and capture a large market share within that region; and,
- The contracts contain a risk-sharing arrangement, whereby the plans and the government share in any savings or cost overruns beyond specified levels.

The private marketplace has developed an efficient and effective model of health plan that meets the needs of enrollees and purchasers as well as providers, in specific local markets. Likewise, the President's framework utilizes the PPO model in order to:

- Cover a wide geographic area, giving those in rural areas new options;
- Offer enrollees a choice of providers at a reasonable cost;
- Include drug coverage;
- Engage providers in quality improvement activities
- Engage enrollees in activities to improve quality such as disease management; and
- Encourage providing innovative benefits to enrollees, such as health education and smoking cessation.

The President's proposed model would rely on regional PPO health plans and have the same types of features. What consumers value most—options—would be the hallmark of the proposed Medicare model. Beneficiaries would be able to choose among the current traditional fee-for-service Medicare, the new enhanced fee-for-service/PPO with an enhanced benefit package, as well as Medicare Advantage, with a tighter network for greater savings.

#### CONCLUSION

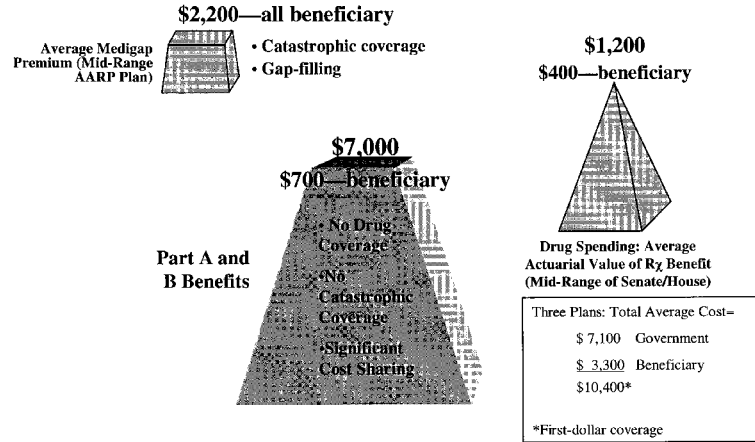
The President's approach for Medicare reform was designed to gradually incorporate the benefits of competition in the provision of Medicare health services. Today all doctors, hospitals, and health providers are paid federally fixed prices for their services. Injecting a modest incentive for performance based on price and quality will lower cost, improve quality, and enhance the performance of Medicare for many beneficiaries. The current health care market has evolved by responding to individuals' desires for provider choice, providing access to state-of-the-art treatment, and offering high quality care. The President's plan is based on combining the best of Medicare—a community-rated social insurance health plan—with the option chosen by approximately 130 million Americans, the flexible PPO benefit model. Improvements to Medicare, however, should not force changes on today's seniors who are satisfied with the current system. They must be able to keep exactly what they have. But seniors who want more benefit options should be able to select better plans—or keep the one they were happy with at age 64.

We want to work together with you to enact significant Medicare legislation this year, and we are encouraged by the bipartisan progress that is already being made. America's seniors and people with disabilities need a drug benefit, and they need modern benefit options in Medicare. America needs a 21st century Medicare plan that provides better coverage, including access to prescription drugs. This is the year to get it done. 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.

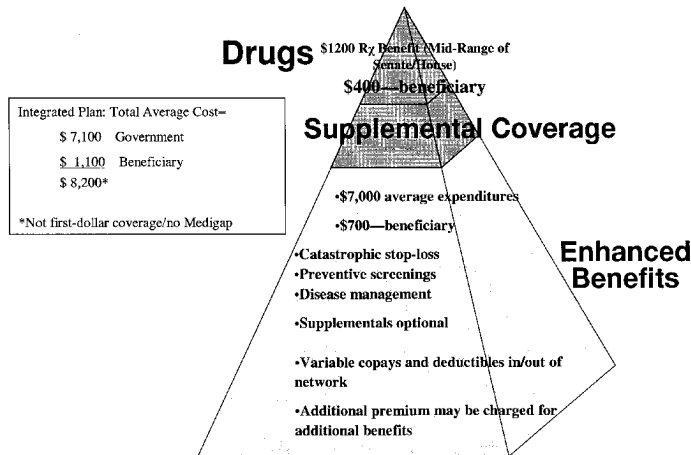
Enclosure.

Illustrative examples only

### Current Medicare + Drug Coverage: Three Uncoordinated Insurance Plans



### Illustrative examples only Enhanced Medicare: One Integrated Insurance Package Providing Medicare Benefits, Supplemental Coverage, and Drug Coverage— In ONE Community-Rated Plan



#### RESPONSES TO QUESTIONS FROM SENATOR GRASSLEY

*Question 1.* Medicare currently provides the same benefit package for beneficiaries throughout the United States, regardless of the area in which they reside. Beneficiaries living in Puerto Rico are eligible to receive the same benefits as bene-

ficiaries who live in any other U.S. jurisdiction. In turn, the beneficiaries in Puerto Rico pay the same Part B premiums, and employers and workers in Puerto Rico pay the same payroll taxes to the federal government.

How would a new Medicare prescription drug program continue to ensure that equal benefits are provided to eligible U.S. citizens residing in Puerto Rico, and in particular, how would it meet the needs of Puerto Rico's low-income beneficiaries?

*Answer.* Both the House and Senate bills make the new Part D drug benefit available to all Medicare beneficiaries regardless of where they live. There are definitional differences between the House and Senate language that may impact Puerto Rico, however. S. 1 requires that beneficiaries must be enrolled in Part A *and* Part B to be eligible for the new drug benefit, while H.R. 1 requires that the beneficiary only be enrolled in one part of Medicare. Since Puerto Rico residents have a special exemption from automatic enrollment in Part B (found in Section 1837(f)(3) of the Social Security Act) there are many Puerto Rico residents among the approximately 2.3 million Medicare enrollees who have Part A coverage only. Many residents of Puerto Rico and the other territories, particularly those with low incomes, cannot afford to pay Medicare premiums and cost sharing. Additionally, while State Medicaid programs on the mainland are required to pay some or all of the costs of Medicare premiums and cost sharing for certain low-income Medicare beneficiaries (QMBs, SLMBs, and QIs), these provisions are optional for the territories (under section 1905(p)(4) of the Social Security Act).

While both the House and Senate bills exclude residents of the territories from the Part D subsidies available to certain low-income Medicare beneficiaries residing in the 50 States and Washington, D.C., the bills do provide for assistance to these beneficiaries. Specifically, both bills provide a special, capped amount of funds to territories that choose to establish a new plan to provide covered outpatient drugs through their Medicaid programs to low-income Medicare beneficiaries (The House bill does not further define the target population group; the Senate bill indicates they would be individuals with incomes below 160 percent of the Federal poverty level, the highest income category allowed under the comparable provisions applicable to States for subsidy eligible individuals). The House bill provides \$25 million for FY 2006, adjusted in future years by the increase in average per capita Part D spending. The Senate bill provides \$37.5 million for FY 2006, then \$50 million for FY 2007, adjusted in future years as in the House bill. In both bills, the funds would be divided among the territories in the same proportion as their current share of capped Federal Medicaid funding. These provisions would not provide identical treatment for residents of Puerto Rico and the other territories, compared with mainland residents, but they generally would be consistent with current Medicaid provisions for the territories.

*Question 2a.* CBO vs. Administration Assumptions on the Costs of PPOs—

In developing a legislative proposal, we have had numerous conversations with both the Administration and CBO regarding the cost of introducing a new Preferred Provider Organization (PPO) option to Medicare beneficiaries—which we will call Medicare Advantage. In these conversations it has become somewhat apparent that CMS actuaries and CBO staff take a somewhat different perspective on the potential costs, savings, and efficiencies of these plans. In fact, CBO assumes that PPOs pay providers more than Medicare pays providers for individual services; they also assume that PPOs have higher administrative costs.

If providers payments are higher in private plans, and private plans spend more on administrative costs than CMS does, why do your actuaries assume that PPOs would be able to provide the same benefits that the Federal Government provides through the traditional Medicare fee-for-service plan for approximately the same costs?

*Answer.* As outlined in a recent CMS issue paper, the CMS Office of the Actuary believes, based on data from the PPO demonstration program in Medicare+Choice, that a great many PPO plans will be able to negotiate payment rates that are at or below Medicare's rates. In addition, PPOs are expected to control utilization better than traditional Medicare, which has a large effect on the total cost of the benefit. These two saving factors, even with the higher administrative costs, are what cause CMS actuaries to predict that PPO plans could cost about as much as traditional Medicare and even achieve a modest savings for the program over time. It is important to note that the actuaries believe there is great uncertainty about these estimates, because no such regional PPO market exists today, so any differences between CMS actuaries and the Congressional Budget Office reflect the results of honest attempts to model the question. Also, the actuaries stress that their predictions are highly sensitive to the details of the market and bidding structure for the PPO plans' details that will be shaped in pending legislation.

*Question 2b.* Doesn't practical experience with large public programs that rely heavily on a partnership with private health plans to deliver benefits—such as FEHBP and CalPERS—suggest that even with higher provider payments, private plans are more efficient in delivering higher quality care at lower costs?

*Answer.* CMS analysis of FEHBP, CalPers and Traditional Medicare suggests that these three systems have roughly comparable performance in containing costs over the long term. Growth in health care costs is largely driven by new and changing technology, including new prescription drugs—factors that impact all three systems. In addition, each system tends to adopt the others' good ideas over time, as evidenced by the fact that many private insurers adopted the prospective payment system for hospital stays developed by HCFA for Medicare in the early 1980s.

*Question 3a.* Ensuring Choice in Rural Areas—

Medicare has offered beneficiaries managed care plans to beneficiaries for several years through the Medicare+Choice program. Yet beneficiaries and plan experience with Medicare+Choice has been mixed. Those who have access to an affordable Medicare+Choice plan have very high satisfaction with their plan. Yet many seniors, particularly in rural areas, aren't offered a Medicare+Choice plan. And those who at one time had access to a plan have lost access due to increasing premiums or the discontinuation of a plan altogether. In fact, 91 percent of rural counties have no Medicare+Choice options. But in FEHBP, 87 percent of rural communities have 6 or more plans available.

I represent a state that has a number of Medicare+Choice plans, but they aren't available in all parts of the state to all seniors. How do we ensure that we set up a new option that will be available to all seniors, especially those in rural areas?

*Answer.* Ensuring access to all seniors, especially those in rural areas, is precisely why the Administration adopted the regional PPO model in its Framework to Modernize and Improve Medicare. By linking together cities and rural areas in one regional service area, the PPO model strives to give all beneficiaries options for their Medicare coverage. The PPO model is flexible enough to work throughout a region. It can function more like an exclusive network in areas where there is provider competition and more like a fee-for-service payer in areas with fewer providers. The evidence for this is clear, as enrollees in the Federal Employees Health Benefits Program (FEHBP) all have access to multiple plans, many of which use a PPO model; and most every hospital in the country, including those in rural areas, have Blue Cross contracts.

*Question 3b.* I know first hand the importance of the bond between a patient and their physician. How do we ensure that relationship is not undermined as we structure a new PPO option?

*Answer.* PPO plans are one of the most loosely managed forms of managed care, so they do not routinely impose the kinds of treatment reviews common to HMOs that some have felt interfered with the doctor-patient relationship. PPO utilization management is typically limited to physician profiling in which a doctor's practice patterns are looked at statistically and the most inefficient providers are removed from the PPO network—and disease management programs, whereby patients with multiple chronic conditions receive additional coordination help to make sure they receive the most complete and costeffective care.

## COMMUNICATIONS

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### STATEMENT OF THE AMERICAN PHARMACISTS ASSOCIATION

The American Pharmacists Association (APhA) appreciates the opportunity to provide our perspective on the critically important topic of reforming Medicare to provide beneficiaries with a benefit that meets current medical standards. APhA, founded in 1852 as the American Pharmaceutical Association, represents more than 50,000 practicing pharmacists, pharmaceutical scientists, student pharmacists and pharmacy technicians. APhA is the nation's first-established and largest national association representing pharmacists in the U.S.

Clearly, an essential element of quality medical care is the provision and use of medication therapy. Prescription medications have become one of our health care system's most valuable tools. Providing a prescription drug benefit to the Medicare population not only would strengthen the program but also takes an important step towards preventing the long-term human and financial costs associated with untreated disease. But prescription medications are only valuable if they are used correctly and appropriately. Misuse of medications is costly, both in health terms and actual dollars. A study of the costs associated with the misuse of medications<sup>1</sup> found that the cost of drug-related morbidity and mortality exceeded \$177.4 billion in 2000—more than double the costs associated with drug-related problems in 1995. As medication experts, pharmacists are best equipped to partner with patients and prescribers to help ensure that medications do what they are supposed to do—such as cure an infection or help manage a chronic illness.

Pharmacists are integral in the health care team's efforts to make sure that patients are making the best use of their medications. As medication experts, pharmacists improve each patient's medication use, work to ensure that patients receive safe and effective medications, and are integral to helping achieve positive health outcomes. To support pharmacists' efforts to manage patient's medication therapy, four components are essential to provide a *quality* pharmacy benefit to patients. A Pharmacy Benefit for Medicare Beneficiaries must:

*Provide Real Coverage, not just Discounts:* Patients must have real access to coverage of their prescription drugs, not simply minimal discounts at the pharmacy counter. Discounts that fail to yield a significant reduction in out-of-pocket costs continue to deny beneficiaries access to valuable therapy.

*Provide Coverage for Medication Therapy Management Services:* Medications are safe and effective *when used appropriately*. Inappropriate medication use leads to hospitalizations, higher costs, and wasted Medicare money spent on drugs which are not used or used incorrectly. Medication Therapy Management Programs would target seniors at high risk for potential medication-related problems, such as those with chronic conditions—asthma, hypertension, and diabetes—and those taking multiple medications. Medicare prescription drug coverage must include payment for these pharmacist-provided services to help patients appropriately utilize their medications and therefore, improve patient health outcomes and quality of care.

*Ensure Patient Access:* Patients must have access to their preferred pharmacy and pharmacist and any qualified pharmacy must be allowed to participate in the program. Patients should not be forced—through economic disadvantages—to choose one pharmacy provider over another. Policies that make it more difficult or costly for a senior to use their choice of provider do not present a true choice to the senior.

*Incorporate Administrative Standards:* A quality prescription drug benefit means not only access to the drug product and medication therapy management services—it also means consumers have access to a benefit that is efficient and free of bureaucratic “red tape”. Standards such as a

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<sup>1</sup>Ernst and Griddle, *J Am Pharm Assoc.* 2001;41:192-9

uniform prescription drug card for all beneficiaries and coverage policies that allow consumers to easily enroll and access their benefit should be part of any prescription drug coverage offered to Medicare beneficiaries. Plan administrators should be required to use on-line, real-time claims adjudication systems to enhance the efficiency of providing pharmacy services to seniors. Moreover, entities should be required to use the latest available technologies to pay pharmacies promptly and efficiently.

With regards to the ever important issue of financing, any new Medicare pharmacy benefit should support—not undermine—the highly-efficient medication services delivery infrastructure, which also provides primary health care services in many underserved communities. Proposals that find most of their “savings” from simply reducing the pharmacy’s payment will be short lived, and may yield substantial harm to the health care system. To remain viable, community health care providers, such as pharmacists, require compensation to cover the costs of providing the prescription product, dispensing the prescription, assuring safe and appropriate use of medications, appropriate overhead costs, and a reasonable profit. Leaving open the possibility for pharmacy benefit managers to unilaterally dictate the terms of pharmacy reimbursement is unfair. Pharmacies and pharmacists are willing to participate within appropriate parameters to make certain that all patients receive the care they need, but they should not have to shoulder the majority of the burden of these “savings”.

APhA appreciates the efforts of the Committee to provide beneficiaries a more robust Medicare benefit that reflects current standards of medical practice. APhA members support a Medicare pharmacy benefit that provides patients with true coverage of medication costs and access to valuable pharmacist services. We would welcome the opportunity to further discuss components of a Medicare pharmacy benefit.

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#### STATEMENT OF THE LONG TERM CARE PHARMACY ALLIANCE

The Long Term Care Pharmacy Alliance is submitting this statement for the record of the Senate Finance Committee’s June 6, 2003 hearing on Medicare reform.

We appreciate the Committee’s leadership in considering issues related to the creation of a new Medicare prescription drug benefit, and we would like to take this opportunity to highlight the special pharmacy needs of the nation’s frail elderly residing in nursing facilities. We want to work constructively with you to ensure the continued provision of quality services to these particularly vulnerable seniors.

While most Medicare beneficiaries are able to walk into pharmacies to pick up their prescriptions or to receive vials of pills through the mail, a sizable percentage of beneficiaries cannot do so and need special services that retail and mail order pharmacies do not provide. Nursing home residents have specific diseases and multiple comorbidities that require specialized pharmacy care. Without such treatment, we cannot expect positive therapeutic outcomes for these patients. Failure to take into consideration the special pharmacy needs of the frail and institutionalized elderly will lead to a marked increase in medication errors and other adverse events.

Pharmacy benefit managers and insurance companies are not equipped to administer a Medicare drug benefit to this vulnerable population, because they lack the necessary experience, infrastructure and expertise. By contrast, members of the Long Term Care Pharmacy Alliance are the nation’s major operators of pharmacies that serve the frail and institutionalized elderly, and they specialize in serving the needs of patients in long-term care settings.

LTCPA members’ patients are elderly, frail, chronically ill, and can no longer care for themselves. They require a level of pharmacy care that goes well beyond what the typical retail or mail order pharmacy provides to its customers. To meet these needs, long-term pharmacies provide specialized packaging, 24-hour delivery, intravenous and infusion therapy services, geriatric-specific formularies, clinical consultation and other services that are indispensable in the long-term care environment.

Without ensuring that nursing-home residents and other patients with special needs can receive these specialized pharmacy services, a Medicare prescription drug benefit could actually endanger the health of beneficiaries residing in nursing facilities. We look forward to working with you on a specific proposal to ensure appropriate coverage of pharmaceutical services for Medicare beneficiaries who reside in nursing homes.

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## STATEMENT OF THE PHARMACIST PROVIDER COALITION

The Pharmacist Provider Coalition is pleased to submit this statement for the record of the Finance Committee's hearing on strengthening and improving the Medicare program.

The Pharmacist Provider Coalition is composed of six national pharmacy organizations, which represent pharmacists working in all sectors of pharmacy practice. The coalition partners joined forces to educate Members of Congress and the public about the role pharmacists play in the safe and effective use of medications and to provide patients access to pharmacist medication therapy management services under the Medicare program. Our membership consists of the following groups: the Academy of Managed Care Pharmacy, American College of Clinical Pharmacy, American Pharmacists Association, American Society of Consultant Pharmacists, American Society of Health System Pharmacists, and the College of Psychiatric and Neurologic Pharmacists.

*Problem: Ineffective Patient Care—Avoidable Medication-Related Complications*

On average, persons aged 65 and older take 5 or more medications each day.<sup>1</sup> The high utilization rate of medications is particularly common in patients who have one or more chronic conditions that call for medication therapy as the primary form of treatment. These medications are often prescribed by several different physicians for concurrent chronic and acute conditions. The cumulative effect of these elements places patients at high-risk for medication-related complications.

Medication-related complications represent up to 11.5% of all hospitalizations. Recently published research indicates that medication-related problems cost the U.S. health care system as much as \$177 billion each year.<sup>2</sup> A substantial portion of this expense is preventable through medication management services provided by pharmacists collaborating with physicians.

*Solution: Pharmacists' Medication Therapy Management Services*

Pharmacists' medication therapy management services help to eliminate unnecessary or counterproductive treatments, assure that patients are receiving the most appropriate drug therapy for their medical conditions, and help patients adhere to what often are complicated medication regimens. As medication experts, pharmacists can identify and prevent duplicate medications, drugs that cancel each other out, or combinations that can damage hearts or kidneys. Pharmacists may also find that a newer multi-action drug may be exchanged for two older drugs or an alternative drug may be substituted for another therapy that causes side effects and results in the patient either taking additional medication or stopping their medication—the result of which may lead to their medical condition worsening. Drug interactions, adverse effects, and low patient adherence with prescribed therapies are costly and preventable medical complications of usual care.

The specialized training pharmacists have in medication therapy management has been demonstrated repeatedly to improve the quality of care patients receive and to control health care costs associated with medication-related complications. As the Institute of Medicine report *To Err is Human: Building a Safer Health System* stated: "Because of the immense variety and complexity of medications now available, it is impossible for nurses and doctors to keep up with all of the information required for safe medication use. The pharmacist has become an essential resource . . . and thus access to his or her expertise must be possible at all times."

Current Medicare payment policies are woefully outdated and fail to recognize pharmacists' services. This restricts the patient's ability to access pharmacists' services. To ensure access, Medicare statutes must be updated to explicitly recognize services provided by pharmacists just as services provided by nurse practitioners, physician assistants, registered dietitians and other non-physician providers have been recognized in recent years.

*Conclusion:*

Pharmacists' medication therapy management services can and will make a real difference in the lives of patients with chronic conditions. This is a logical and very affordable step towards eliminating barriers to chronic care management and establishing the essential infrastructure of a Medicare prescription drug benefit. The Coalition strongly encourages the Committee to pass legislation to provide patients' access to pharmacists' provided medication therapy management services.

<sup>1</sup> ASHP Consumer Survey, "Medication Use Among Older Americans", 2001.

<sup>2</sup> Ernst FR, Grizzle, AJ. Drug-Related Morbidity and Mortality: Updating the Cost-of-Illness Model. *Journal of the American Pharmaceutical Association*. 2001: Mar-Apr; 41(2):192-199.

Thank you for the opportunity to present the views of pharmacists who care for Medicare patients on a daily basis.

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STATEMENT OF THE PREFERRED PROVIDER ORGANIZATIONS (PPOs)

Preferred Provider Organizations (PPOs) are a form of fee-for-service health insurance coverage whereby enrollees can go to any health care provider who will be reimbursed for the services furnished. PPOs are a growing form of health insurance and are now the most popular type of coverage in the private insurance market. This paper lays out the facts about PPOs and the prospects for them to deliver benefits to seniors and the disabled while controlling costs and enhancing quality.

- PPOs are the most popular form of health insurance in the employer group market today, covering 52 percent of enrollees. Together with the very similar Point of Service (POS) model that covers 18 percent of enrollees, 70 percent of insured Americans are in these “hybrid” plans. Traditional fee-for-service (FFS) plans represent only 5 percent of the market. By contrast, 87 percent of Medicare enrollees are in traditional FFS.
- PPOs give beneficiaries a wide choice of providers, allowing them to stay within the PPO network for maximum cost savings or go outside the network if they desire. Moreover, benefit enhancements include greater coverage of preventive care as well as coordination of health care services.
- The PPO design is flexible enough to work well in both cities and rural areas.

Applying the principles outlined in the Administration’s Framework to improve the Medicare program, the CMS actuaries estimated that the average cost in competitive private plans, including PPOs, would be less over the 10-year period than the corresponding cost in traditional Medicare. These savings would continue to grow over time. In addition, beneficiaries would receive better and more enhanced services including full coverage for preventive care. The cost reduction trend in PPOs results primarily from two factors. First, over time, beneficiaries enrolling in PPOs would tend to switch from more expensive plans to less expensive ones because, over time, they would have the option to reduce their monthly premiums. And second, the cost growth rates for PPOs are expected to be slightly less, on average, than increases in Medicare fee-for-service costs.

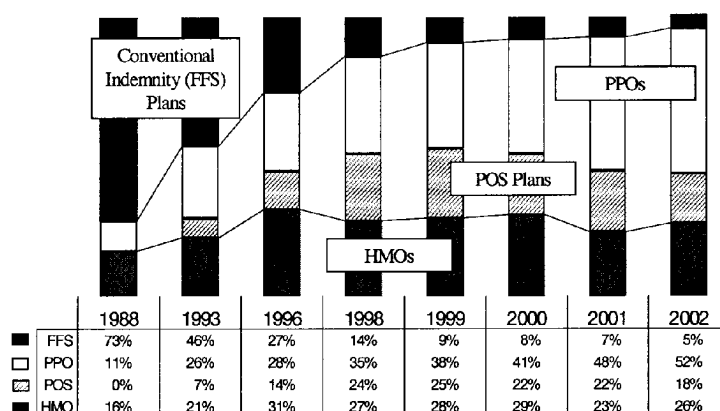
The actuaries’ estimate was derived from data that PPOs provided in solicitations for CMS’ PPO demonstration. These data suggest that the most efficient plans have the potential to beat Medicare’s costs by an average of 2.3 percent. Not all PPO plans in the demonstration are that efficient, however, which is why the specific design features matter greatly. The potential for savings in Medicare depends critically on whether:

- Beneficiaries are given the option to choose the most efficient plans and save money on their premiums;
- The bidding process accepts only a limited number of PPOs per region, so that plans bid aggressively and capture a large market share within that region; and,
- The contracts contain a risk-sharing arrangement, whereby the plans and the government share in any savings or cost overruns beyond specified levels. Again, this allows plans to bid more aggressively.

## Preferred Provider Organizations: What are they?

### Shares of Employer Group Market in PPOs, POS Plans, HMOs, and Conventional Indemnity, Selected Years, 1988-2002

*Over the past 10 years, the trend in the private market has been towards network plans that give enrollees provider choice. In 2002, 70% of individuals were in such plans (PPOs and POS plans). Only 5% of the market was in conventional indemnity plans.*



Source: Kaiser/HRET or KPMG Survey of Employer-Sponsored Benefits. Numbers may not add to 100% due to rounding.

PPOs have been a growing form of health insurance and are now the most popular type of coverage in the private market. Among individuals with employer group coverage, 52 percent are enrollees of PPOs and 18 percent are in the very similar POS plans as of 2002.<sup>1</sup> For example, the most popular plan for Federal employees covered through the Federal Employees Health Benefits Program (FEHBP) is the Blue Cross and Blue Shield PPO, available throughout the nation: 51 % of those covered by FEHBP in 2002 were enrollees of the BCBS PPO. Of large employers, 78% offer a PPO option to pre-65 retirees.<sup>2</sup> As a result, PPOs are very familiar entities in the marketplace, and today's workers will age into Medicare with experience with PPO coverage.

In PPOs, enrollees can go to any provider and receive reimbursement for the services they receive. This is also true of traditional fee-for-service indemnity plans, but the critical distinction is that PPOs have networks. What at the enrollee must pay for services depends on whether the provider is a preferred provider (i.e., a provider that is part of the network), or a non-preferred provider. Generally, enrollees face higher out-of-pocket costs if they see a non-preferred provider. There may also be certain rules that apply when the enrollee uses a non-preferred provider: for example, the insurance company may require prior authorization for a hospital stay if a non-preferred hospital is used, but there would be no such requirement if a preferred provider is used.

Preferred providers enter into contractual arrangements with the PPO insurer to accept agreed upon payment levels, with the enrollee's financial obligation often limited to a fixed co-payment (after a deductible) or a fixed coinsurance amount in relation to the agreed-upon fee. Within a PPO, providers (both preferred and non-preferred) are generally paid on a fee-for-service basis for their services. As part of the agreement between an insurer and the preferred providers of a PPO, the preferred providers may also agree to other contractual provisions, including, for example, filing claims on behalf of enrollees, and participating in quality improvement projects.

<sup>1</sup> Kaiser Family Foundation/HRET, 2002.

<sup>2</sup> Kaiser/Hewitt, December 2002

When a non-preferred provider is used, the reimbursement generally is similar to a traditional indemnity plan. The non-preferred provider receives payment from the insurance company at a specified level determined by the insurer, and the enrollee is responsible for the remainder of the bill.

The popularity of PPOs is a factor in their ability to attract providers to join the PPO network. Because enrollees have financial incentives to use preferred providers, they can expect to see a higher volume of insured patients as compared to non-preferred providers (depending on local market circumstances).

#### HOW PREFERRED PROVIDER ORGANIZATIONS WILL HELP MEDICARE BENEFICIARIES

The President's approach for Medicare is based in the health care market of today, with insurance coverage that most insured Americans under age 65 have and want to retain. The U.S. health care system has evolved to where it currently is by responding to individuals' desire for provider choice, access to state-of-the-art treatment, and high quality. Good private health insurance provides a comprehensive integrated package that includes prescription drugs, preventive services, and protection against catastrophic expenses. The private market uses a model that can adapt more quickly to local conditions and respond to the needs of consumers and health care providers.

#### *Medicare's History*

The design of the Medicare program was based on the private system of health insurance prevalent in 1965—both in terms of the benefit package and how the program was to be administered. The administration of the program has always been through the private sector, by the use of contractors such as Blue Cross plans and other insurers that became the “Intermediaries” and “Carriers” that would work directly with providers (with only minor exceptions of providers being paid directly by the government). The prevalent model of health plan coverage in 1965 was fee-for-service indemnity coverage, whereby an insurance company (largely Blue Cross and Blue Shield plans) picked up a portion of the costs of any covered services submitted by any licensed provider. Similarly, the Medicare program was designed as an “any willing provider” program, whereby all providers could bill for their services (if they were licensed and met conditions of participation); the program would pay all or a portion of the charged amount; and Medicare would not interfere with the practice of medicine. At the same time, in 1965 Medicare recognized the existence of private health plans with limited provider networks (prepaid health plans) that were allowed to participate in the program under alternative payment arrangements. Medicare was designed as a national program, but from the beginning of the program it was recognized that the program should reflect the regional nature of health care—for example, Carriers would be regional Carriers, and coverage decisions could vary by region.

#### *Thirty-Eight Years of Change in the Health Insurance Market*

Since 1965, the private sector has witnessed major changes in the structure of health care insurance with regard to the benefit package, how services are obtained and paid for, the relationship between providers and insurers, and the role that insured individuals play in health care decisions.

#### *The benefit package*

In the private sector today, prescription drugs generally are covered, and preventive services are promoted. In addition, insurers now use a single policy structure for hospital, doctor, and other coverage (with a single deductible) and typically include protection against catastrophic costs. Some of these features have their origins in the coverage offered by HMOs, which traditionally emphasizes preventive services and generally cover drugs. HMOs cover drugs for various reasons: drugs form a part of integrated care and drugs may substitute for more costly care. Moreover, HMOs can afford to cover drugs because they are more cost efficient than indemnity plans. Drug coverage allows HMOs to compete with indemnity plans, since enrollees can obtain better coverage in exchange for exclusively using a network of providers. Now, essentially all private sector plans have incorporated drugs and extensive preventive care into their benefit packages.

#### *How services are obtained and paid for; the relationship between plans and providers*

Under traditional indemnity insurance, all providers in the same class (within a geographic area) are treated equally in terms of payment—there is no negotiation over price, volume or quality. In the current environment in the private sector, health plans have recognized that not all providers merit equal treatment and that

financial incentives are a powerful tool to achieve better outcomes. Today, insurers actively negotiate payment arrangements with providers and provide financial incentives to providers to improve the quality and efficiency of care. This is done through a range of payment and contracting arrangements, such as establishing preferred networks of providers, incorporating bonuses as part of the payment structure, or—something that is becoming less common—by putting providers at risk for services (provider capitation). The nature of these arrangements changes over time and varies significantly by geographic area, with private health plans responding to market conditions in a given area or adjusting to new circumstances (e.g., consumer preferences) that can change in a short time.

Medicare, as a national program with payment practices and provider participation rules determined mainly by statute, does not negotiate rates, but fixes prices to all providers, regardless of price, volume or quality. It has no flexibility to respond to local market conditions and to rapid changes in the health care system. A national program can only use very blunt tools to address differences among markets. Ironically, it is Medicare claims data that have shown just how much variation there is in health care costs across the country, and which formed the basis of extensive research showing that higher health care expenditures do not yield better outcomes—that is, that the health care system can be much more efficient than it currently is without sacrificing the quality of care. Medicare as a national “any willing provider” program is required to provide equal payment to all providers, even if this approach hampers the program’s overall goals. When Medicare has been able to make distinctions among providers—e.g., in the Centers of Excellence demonstrations—the results have been improved outcomes at lower program costs.

Whether, and on what basis, to treat providers differently is a complicated issue that often requires an intimate knowledge of local market conditions. A national program cannot make these local market-level distinctions. For example, if the current situation of physicians opting out of Medicare or choosing not to take new Medicare patients has arisen because of low payment and the problem is only seen in certain geographic areas, Medicare has no way of quickly making an adjustment to physician payments that is limited only to certain geographic areas. Private health plans respond to such issues on a routine basis, as they negotiate and renegotiate contracts from one year to the next or respond to service access issues at any point in time.

*The role that insured individuals play in health care decisions*

Health plans encourage the use of preventive services by eliminating cost sharing (as Medicare has done, but only for a very limited set of services). Health plans encourage the use of particular providers or services by having differential payment structures depending on the type of provider used (preferred versus non-preferred, for example, or hospital inpatient versus outpatient setting). Private health plans also provide services such as disease management programs, telephone nurse advisers, health education, and smoking cessation programs that enable enrollees to maintain and improve their health status. While health plans design their products to meet the needs of their customers, enrollees also have a significant “voice” in the structure of the health care system when there is competition among health plans. At the interplan market level, individuals play a role because they are the buyers of health care (either directly or through a sponsoring organization, such as an employer).

REGIONAL PPO PLANS: THE BEST FIT TO THE MARKETPLACE

In order to succeed in a competitive market, to ensure the most efficient product, to respond to the demands of consumers, and to understand the dynamics of a local market, an organization must have a local market presence. Although many health plans are chain organizations operating in multiple markets, such organizations are usually not nationally administered plans, and many provide significant autonomy to the regional plans under the umbrella of the larger organization. Most health plans continue to be regional in nature, with a strong presence in particular States or geographic areas. While the federal employees health benefits program (FEHBP) has been able to operate a nationally<sup>3</sup> and locally designed competitive model, the size of the Medicare population and its geographic dispersion are such that there are not a sufficient number of health plans available to competitively function under a nationally based model for Medicare.

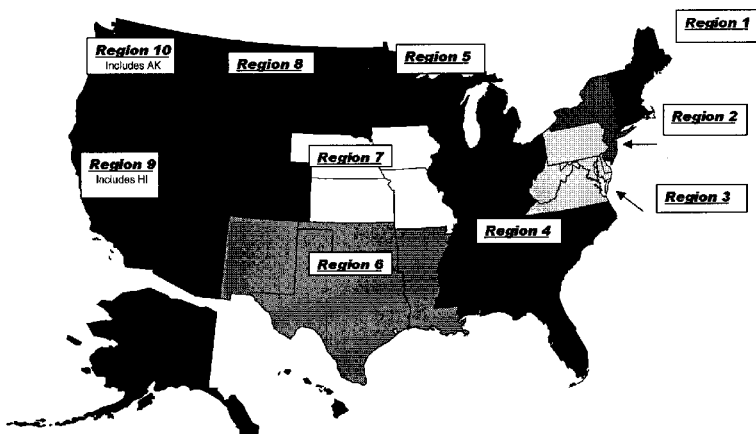
<sup>3</sup> National plans in FEHB are really a collection of regional plans that deal with the federal government through their common agent or association.

A health plan must also meet the demands of purchasers that are looking to insure a specific population. Many employers have employees and retirees that live in a wide geographic area, including rural areas. Health plans that provide coverage for such employers cover all employees, regardless of where they live. The vast majority of hospitals operating in rural counties—including counties where there is only one hospital—have Blue Cross contracts that are almost always part of a PPO. Contracting with a PPO makes economic sense for rural providers. Such contracts provide a stable, reliable source of revenue from an insured population in the areas of the country that have higher rates of uninsured individuals. If large numbers of Medicare beneficiaries enroll in the new PPO plans Medicare will offer, both incentives will operate to make rural providers more likely to contract with PPOs: the population is already a primary source of revenue for the providers, which they would like to retain, and the individuals will continue to be insured individuals offering a reliable, stable source of revenue. It is a simple fact that virtually all rural hospitals in truly rural states, from North Dakota to Wyoming to New Mexico, have contracts with their Blue Cross plans.

In looking at other successful models, the military's TRICARE program relies on a design of regionally based plans. A similar regional design provides an approach in which the Medicare population is divided into reasonably sized groups. In fact, the current program is administered through a regional design. Using the competitive design features found in FEHBP and other employer sponsored health insurance programs, combined with the regional model of TRICARE (but using the current Medicare based ten regions), produces a program that delivers the best features found in the market place today.

The private marketplace has gravitated towards a particular model of health plan that meets the needs of enrollees and purchasers as well as providers. A regional PPO model:

- Covers a wide geographic area, including rural areas;
- Offers enrollees a choice of providers at a reasonable cost;
- Includes drug coverage;
- Engages providers and enrollees in quality improvement activities; and,
- Offers innovative benefits to its enrollees.



The proposed model for Enhanced Medicare would have the same features and would rely on regional PPO health plans. What consumers most value—options—would be the hallmark of the proposed Medicare model. Beneficiaries would be able to choose among the current traditional fee-for-service Medicare, the new enhanced fee-for-service/PPO with an enhanced benefit package, as well as the choice of the current types of Medicare+Choice plans.

The new fee-for-service/PPO approach would offer beneficiaries a choice of multiple PPO plans in a geographic area, and within each PPO, all beneficiaries would have an enhanced benefit package and full choice of providers in every city and county in the nation.

## PPO COSTS RELATIVE TO MEDICARE: DESIGN MATTERS

PPO-style health plans have the potential to control costs as well as or slightly better than traditional Medicare over time, according to analysis done by the CMS Office of the Actuary. It is important to remember, however, that any potential savings or costs depend critically on the proposal itself. **Program design matters.** The bidding process, risk sharing arrangements and beneficiary incentives all combine to determine whether a PPO option saves a modest amount or costs significantly more. This section outlines some of the data that CMS actuaries used to model a regional PPO offering, as well as the design features and plan practices that affect the cost estimates.

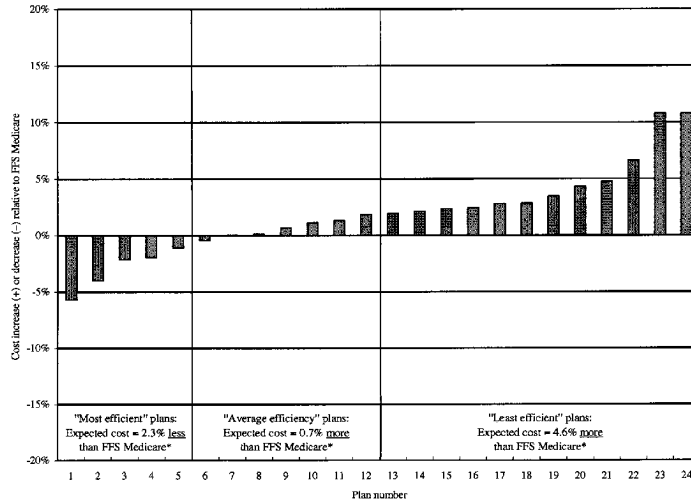
*How CMS Office of the Actuary Scored a Regional PPO Approach*

Under the principles of the Administration's Framework to improve Medicare, the CMS actuaries estimated that the average cost for beneficiaries in competitive private plans, including PPOs, would be less over the 10-year period than the corresponding cost under traditional Medicare. These savings would continue to grow over time. The cost reduction trend in PPOs results primarily from two factors. First, over time, beneficiaries enrolling in PPOs will tend to switch from more expensive plans to less expensive ones, because unlike today, they can reduce their monthly premiums. And second, the cost growth rates for PPOs are expected to be slightly less, on average, than increases in Medicare fee-for-service costs. Both of these factors, and others affecting the estimates, are explained in greater detail below.

*What the Data Show*

**EFFICIENCY**—CMS actuaries analyzed the ACR data submitted by plans for the CMS PPO demonstration. The analysis was limited to large PPOs covering a fairly wide geographic area. Efficiency ratios, defined as costs for PPO demonstration plans relative to traditional Medicare, were calculated for each PPO plan. Chart 1, below, summarizes these ratios for the 24 PPO submissions. As indicated, the most efficient plan expected to incur per-enrollee costs that were about 5.7 percent lower than the corresponding costs under FFS Medicare. At the opposite extreme, the least efficient plan would cost nearly 11 percent more than FFS. (Note that in the Framework, beneficiaries will have the incentive to choose the most efficient plan and save money on their premiums. In addition, those choices are expected to encourage plans to bid more aggressively over time. Also note that in the demonstration, plans receive the higher of 99 percent of the AAPCC rate or the Medicare+Choice rate—and had an incentive to report higher costs.)

Chart 1—Overall net cost (+) or savings (-) for PPO demonstration plans, relative to fee-for-service Medicare  
 ---Large PPOs, by overall efficiency level---



\*Plans are grouped such that each efficiency category has one-third of total projected enrollment.  
 SOURCE: CMS Office of the Actuary, March 31, 2003

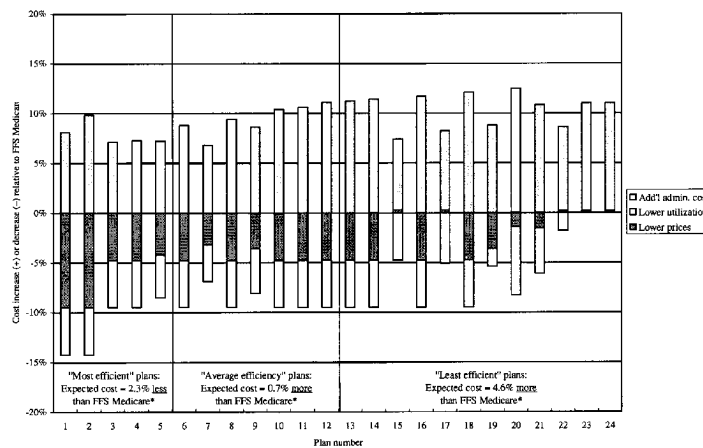
The demonstration plans were then divided into three groups—the most efficient plans, average efficiency plans, and inefficient plans. Each group covers one-third of the total projected enrollment in the PPO demo. Chart 1 also indicates these groupings. The weighted average cost for the most efficient PPO group was 2.3 percent lower than FFS. The average efficiency group was 0.7 percent higher than FFS, and the least efficient group was 4.6 percent higher, on average.<sup>4</sup> The actuaries assumed that these expected efficiency ratios from the PPO demonstration plans would be representative of the three winning PPO bids in each region under the Administration's Framework.

**ELEMENTS OF OVERALL EFFICIENCY**—Chart 2 (below) shows the components of these overall cost/savings expectations. These components are drawn from the data submitted by the PPO demonstration applicants, together with additional data collected in conversations with each plan's actuaries. These data generally showed that PPOs expected to negotiate prices that were 0 to 5 percent better than FFS prices and that they could achieve savings of another 2 to 5 percent through utilization management. However, on the cost side, their administrative expenses were in the 8 percent to 13 percent range, compared with 2 percent or less for FFS Medicare. The most efficient PPO in Chart 2 (plan one at left) expected to pay prices that were 9.5 percent lower than FFS, to achieve another 4.75 percent savings through utilization management, but to have administrative costs (including marketing expenses and profit) that were 8.1 percent higher than FFS. Collectively, these factors result in the most efficient plan expecting overall net savings of 5.7 percent mentioned previously. Conversely, the least efficient PPO in the sample expected to pay prices that were 0.2 percent higher than FFS, to achieve no savings through utilization management, and to incur an administrative loss ratio nearly 11 percent higher than FFS. Again, with the way premiums are set, beneficiaries will have the incentive to choose the more efficient plans and reduce their own monthly premiums.

<sup>4</sup>Overall, the 24 PPO demonstration plans had an average cost level that was 1.0 percent higher than Medicare FFS and 6.1 percent higher than Medicare+Choice HMOs in 2003. For comparison, for Medicare-eligible beneficiaries in the Federal Employees Health Benefit Program, PPO costs are about 11 percent greater than HMO costs. Such costs are for benefits supplemental to Medicare and reflect the substantially richer coverage provided by the PPOs in comparison to the HMOs under FEHBP.



Chart 2—Comparison of expected price savings, utilization-management savings, and admin. costs for PPO demonstration plans, relative to fee-for-service Medicare  
—Large PPOs, by overall efficiency level—



\*Plans are grouped such that each efficiency category has one-third of total projected enrollment.  
SOURCE: CMS Office of the Actuary, March 31, 2003

The price, utilization, and administrative cost factors described above merit additional discussion. First, questions have been raised as to whether PPOs can negotiate better prices than the Medicare FFS prices imposed on providers by law. Studies by the Medicare Payment Advisory Commission (MedPAC) have consistently indicated that Medicare payment rates to physicians and hospitals are significantly lower than the average for other payers. The results of these studies appear to contradict the expectations of the demonstration PPOs that they could establish the same or lower payment rates as Medicare FFS. Pending further investigation, the CMS actuaries continue to believe that the performance expectations of actual PPOs—which were willing to risk their organizations' financial well-being—are the best indicator of price levels under a Medicare PPO option.

Additional support for this assumption is suggested by the experience with the Federal TRICARE program<sup>5</sup> and the Medicare+Choice program. Consulting actuaries working with TRICARE have indicated that the winning contractors have negotiated payment rates that are lower than Medicare's. Similarly, there is substantial anecdotal evidence that HMOs under Medicare+Choice have often negotiated payment rates below FFS levels. However, the ability of health plans to negotiate bottom dollar prices can be hindered by extreme levels of provider consolidation. Virtually all of the hospitals on Long Island, New York, for example, have aggregated into just two groups and have refused to participate in any M+C plan's network. In this way, they can force the HMOs to pay the "out-of-network" default Medicare FFS prices, rather than the lower prices previously negotiated by the HMOs. Similarly, TRICARE encountered problems in North Carolina with consolidation of physician practices. It is difficult to judge at this time whether further provider consolidation will reverse past plan successes in negotiating prices, or whether antitrust considerations will limit the extreme levels of consolidation that have started to appear.

Regarding the potential savings from utilization management, PPOs can affect utilization in several ways. Many PPOs review the practice patterns of physicians and advise them if they find an unusually high incidence of services, excessive hospitalizations, or unnecessary use of very expensive procedures. In extreme cases, physicians may be dropped from the plan's provider network.

<sup>5</sup> TRICARE provides health insurance coverage for military service retirees and families of active military personnel. It operates in 12 multi-state regions, covering roughly 4 million participants, and awards the coverage contract for each region to a single winning contractor.

Administrative costs for private, state, and many other federal health plans will generally be significantly greater than for Medicare FFS. It is unrealistic to expect that plans could beat Medicare on this front. Traditional Medicare operates with an enormous economy of scale, it is non-profit, has negligible marketing costs and zero risk-management costs such as the cost of reinsurance, and it performs only very minimal reviews of service use. Private plans, conversely, are much smaller and typically incur these other categories of costs. As noted above, the large PPOs that expressed interest in the CMS demonstration had expected administrative loss ratios (ALRs) in the range of 8 to 13 percent. By comparison, ALRs for the national PPOs in the Federal Employees Health Benefits Program range from 6 to 8 percent. This lower level reflects a greater economy of scale, due to their size, and also the fact that FEHBP plans are not reimbursed for marketing costs. Adjusting for typical levels of marketing costs and profits, the FEHBP ALRs are still somewhat lower than the PPO demonstration plans. In estimating the financial impact of Medicare PPO options, the actuaries have used the PPO demonstration data, without adjustment.<sup>6</sup>

*Mapping the Data to a Regional Bidding Model*

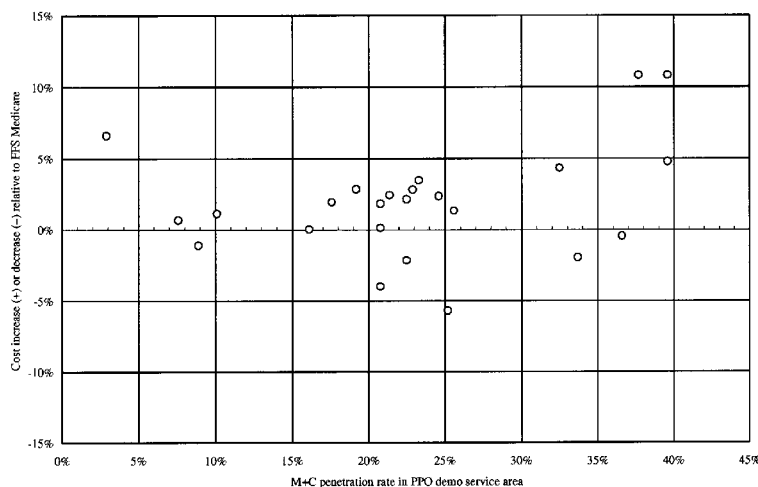
As noted above, the actuaries assumed that the weighted average efficiency ratios calculated for the three groups of PPO demonstration plans would be representative of the three winning PPO bids in each region. Consequently, they estimated that the lowest of the three winning PPO bids in each region would initially be 2.3 percent below FFS costs, the middle bid would be 0.7 percent above FFS, and the high bid would be 4.6 percent more than FFS. The actuaries did not make the more aggressive assumption that the winning bidders would look like the three most efficient plans on the far left of Chart 1. They chose a more conservative assumption knowing that the PPOs that were willing to participate in the demonstration are already a select group, probably more efficient than the typical PPO, as evidenced by the fact that they were willing to participate in the demonstration at specified payment rates.

CBO has questioned this assumption on the grounds that the demonstration plans tend to be in areas with relatively high fee-for-service costs and that these plans' experience might not be matched in other parts of the country. This is a legitimate concern. However, to help evaluate this possibility, Chart 3 compares (i) the net cost or savings for each of the 24 PPO applicants, to (ii) the level of Medicare+Choice enrollment prevailing in the PPOs' service areas. If the demonstration plans are "cherry picking" areas based on the capitation rates offered, then one would expect PPOs to fare best where the payment rates are the most attractive compared to plan costs—that is, the areas where M+C plans are most likely to participate under current law. As indicated in Chart 3, there is no apparent relationship between these two factors. In fact, examples of the lowest and highest cost PPOs can be found in low-penetration areas of the country as well as high-penetration areas. Similarly, each of the separate price, utilization-management, and administrative loss ratio factors showed no pattern by M+C penetration rate.

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<sup>6</sup>Some proposals have considered limiting PPO marketing costs and/or placing an overall cap on administrative expenses.

Chart 3—Comparison of overall net cost (+) or savings (-) for PPO demonstration plans, relative to fee-for-service Medicare, by prevailing M+C penetration rate in same area  
—Large PPOs—



SOURCE: CMS Office of the Actuary, March 31, 2003

There is reason to believe that a well-structured PPO bidding system could attract greater efficiency from plans. Other evidence suggests that the administrative loss ratios for the PPO demonstration plans may not be especially efficient. The CMS actuaries consulted with other actuarial experts in PPO plans, who stated that it is possible that the “lowest bid” plans under a truly competitive system could have better efficiency than we assumed based on the demonstration plans.

In the view of the CMS actuaries, these issues tend to counterbalance the CBO concern that the demonstration data could not be replicated elsewhere in the U.S. Accordingly, the actuaries believe it is reasonable to model the competitive impact of a three-winning-bidder approach by using the three groups of PPO demonstration plans. They recognize the desirability of reducing the uncertainty of this critical assumption through further analysis and additional data.

#### Design Matters

An important element underlying the potential for savings through competition involves the “**dynamics of plan choice**” by beneficiaries. In both the Administration’s Framework and some recent legislative proposals, beneficiaries who enroll in a more efficient plan can reduce their premiums by 75 percent of the cost difference. Conversely, beneficiaries selecting higher-cost plans must pay all of the additional cost. This provision gives beneficiaries a significant financial incentive to enroll in more efficient plans. Based on assumptions outlined in the Administration’s Framework, the migration of beneficiaries to more efficient plans would affect the “benchmark” for payments to plans, adding further to the plans’ incentive for efficiency and contributing to additional savings. The benchmark would be based on the weighted average bid of the winning PPOs. As beneficiaries enroll in the less expensive plans over time, the weights will shift toward these plans, thereby lowering the benchmark. Other things being equal, a lower benchmark reduces the government share of total plan costs and a higher benchmark increases it. This effect would not occur in proposals that would establish a benchmark independently of the PPO bids.

Another factor in determining PPOs’ costs is whether or not there is any type of **risk-sharing** arrangement. Most of the plans in the PPO demonstration had a risk-sharing arrangement whereby the plans and the government share in any savings or cost overruns beyond specified levels. Without such arrangements, plans generally bid more conservatively (higher) by increasing their “risk premium,” the extra charge needed to cover the possibility of a greater financial loss. The actuaries estimated a small, net increase in PPO costs if there is no risk-sharing mechanism.

Risk sharing is also likely to increase the number of PPOs that would bid to participate in a Medicare PPO option. In the early days of TRICARE, for example, the risk-sharing arrangements were not adequately specified, and two large PPOs dropped out of the bidding due to concern over risk levels. The more plans that participate in the bidding, the more competitive the process will be.

Finally, the **number of PPO plans** that are allowed to participate in the program also affects the potential for cost savings. If all PPO plans wishing to participate were permitted to do so, then the potential savings could be substantially affected. First, with a limited number of winning bidders, plans have a strong incentive to maximize their efficiency and to bid aggressively. This incentive would be greatly reduced if all plans can participate. In addition, with unlimited plan entry, it is possible that no plans would be able to capture enough market share to take advantage of economies of scale. This could also affect a plan's decision on whether or not it would be worthwhile to participate at all.

#### *Other Factors*

In addition to the factors that are PPO specific, there are two additional sources of potential savings in a competitive environment. First, private plans are expected to react more quickly than Medicare to changes in provider strategies. Some providers find new creative ways to receive higher Medicare payments, some of which are legitimate and some of which may not be (for example, over \$2 billion in inappropriate hospital outlier payments in 2002 alone). In calendar year 2002, Medicare expenditures for a number of service categories increased at unusually rapid rates, including 20 percent for durable medical equipment, 24 percent for hospice care, and 14 percent for home health services. Within the DME increase, expenditures for powered wheelchairs grew by 54 percent and have averaged growth of over 40 percent for the last five years. Although CMS will identify and respond to trends in high growth areas, private plans are able to react more quickly to address over-utilization. The actuaries estimate that this factor would result in a slightly lower level of costs, on average, for privately administered plans.

The second factor is productivity. With the exception of payments to physicians and ESRD facilities, by law Medicare payment updates to providers are based on "input price" increases.<sup>7</sup> If providers are able to be more productive, they won't need to increase their charges by as much as the increase in the price of their inputs. Current literature suggests that hospitals are experiencing productivity increases of 0.4 percent to 0.5 percent per year. Although the actuaries recognize that some providers, such as skilled nursing facilities and home health agencies, are too labor intensive to be able to achieve these gains, private plans should be able to negotiate payment increases that are slightly less than the input price updates paid by traditional Medicare.

#### *Lessons for Legislation*

As cautioned previously, the financial impact of any Medicare PPO option would depend critically on the specific provisions of the proposal. The Administration's Framework was designed in ways intended to optimize the potential benefit of increased competition in the provision of Medicare health services. For proposals of this type, the actuaries estimated a modest degree of savings compared to current law, based on the data, assumptions, and methods described in this note. There is still substantial uncertainty inherent in estimating the impact of major changes to the Medicare program, for which there is relatively limited data. Policy makers should be aware of this uncertainty and recognize that actual future experience could differ significantly from estimates.

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<sup>7</sup> Input price indices reflect changes in the prices paid by providers for the goods and services they purchase in order to provide health care services. Wages and salaries paid to employees are a major component of these input prices.

Public Citizen  
215 Pennsylvania Avenue, SE  
Washington, D.C. 20003

June 19, 2003

Senate Finance Committee  
219 Dirksen Senate Office Building  
Washington, DC 20510-6200

Re: June 6, 2003 Hearing: "Strengthening and Improving the Medicare Program"

Public Citizen would like to submit for the record the following response to testimony given on June 6, 2003 before the Senate Finance Committee hearing on "Strengthening and Improving the Medicare Program."

We are responding to criticisms made by Mr. Walton Francis, a witness on the 2<sup>nd</sup> panel, regarding our report "Bush Plan to Privatize Medicare: Limiting Patient Choice of Doctors in Five States." In the report, which is attached, we looked at how many doctors that participate with Medicare in 20 counties in 5 states also participate with the private insurance PPO plans that are part of the Federal Employee Health Benefits Program. We found that less than half of the generalists that participate with Medicare participate with the private plans. This means that if Medicare beneficiaries choose to leave traditional Medicare and enroll in a private plan there is a high probability that their doctor would not participate with the plan they choose.

Francis is critical of our decision to limit the search for doctors available under private plans to the boundaries of selected counties. He comments that if beneficiaries look outside of their home counties there will be more doctors available through private plans than our report indicates. He is correct, but this argument does not undermine the central claim of the report. We do not argue that there are no doctors in private plans. We argue that many of the doctors that participate in Medicare do not participate in FEHBP's private plans.

If our study were redone for geographical areas larger than a county there is nothing to suggest that the results would change. There would be more doctors that participate in private plans and there would be more Medicare participating doctors. And our study suggests that if a beneficiary were seeing a Medicare participating doctor outside of their home county and they switched to one of FEHBP's PPO plans there is a high likelihood that their doctor would not participate in their new plan. They could continue to see that doctor, but because he or she would be an out-of-network provider the beneficiary would pay more, perhaps significantly more, to be treated by them.

Thank you for the opportunity to respond to Mr. Francis' testimony.

Sincerely,

Ben Peck  
Legislative Representative  
Public Citizen's Congress Watch

Enclosure: Public Citizen report, "Bush Plan to Privatize Medicare: Limiting Patient Choice of Doctors in Five States"

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#### STATEMENT OF KATHY SZEMERSKY

##### A TRIBUTE TO THE MEMORY OF MY MOTHER ON MOTHER'S DAY 2003

I just returned from my mother's grave today. I cleaned the winter debris from her grave and honored her with a single red rose laid at her headstone. It was her favorite flower. I now have to wonder now if she knows? Do you have a mother, father, sister, brother, aunt, uncle or grandparent in a US nursing home? Are you a committed caregiver and advocate for your infirm, frail, sick, elderly or disabled relative? Are you aware of what they are experiencing on a day to day basis? Then read on.

As many of you may know this also National Nursing Home Week. While I find that these two occasions of special observance contradict one another in the most ironic way, it is the most appropriate time to share the story of my mother's suffering and death, in a rogue Michigan nursing home and hospice. My mother's death may have been inevitable, but her suffering was barbaric. The nursing home care was tolerable and on occasion "acceptable" until it was purchased by new owners late spring summer 2000. The quality of care plummeted from both the nursing

home and hospice about the same time. I was so busy feeding, bathing, changing, laundering, housekeeping, monitoring medical needs and grooming my mother that I failed to see all of the warning signs. Nursing homes and hospices, as I found out much later, have a type of "joint operating" agreement. And some hospices, according to a report by the General Accounting Office of the US Government, make their profits from withholding services from terminal patients in nursing homes.

My mother emigrated to the United States from Central Europe in the late 1950's, with a young daughter. She later became a US citizen. My mother was to serve as primary caregiver for a crippled brother. She did this for 16 years and raised the daughter without the luxury of the English language or a vehicle. She cooked, cleaned, gardened and shopped. She provided 24 hour nursing care, in the home, when her brother became terminal and comatose following a major stroke. He died peacefully in his own bed without a single bruise, malnutrition, dehydration nor bedsores.

My 89-year-old mother died on Thanksgiving Day, November 2000. In my opinion, experiences, and observations, she died as a combination result of advanced age, suspected but undiagnosed cancer, dementia, severe depression, malnutrition, dehydration, general neglect and abuse. Nurses notes document that my mother, 4 days before death, semi-comatose, moaning in pain had no ROXANOL pain medication. 7 days before death, a hospice CENA ripped her right calf open transferring her from bed to wheelchair, while semi-comatose. On the day of death, my mother had a necrotic hip-sacrum bedsore, stage 3, approximately 7 inches diameter, among several others. In the last 8 months of her life, on most visits I found her saturated in either urine, feces or both.

My mother was a robust, feisty, independent, strong-willed and determined woman. This all changed in an instant following a fall at the nursing home, where 2 days later it was determined that she suffered a broken hip and required hip-replacement surgery. She was mad as "Hell", but recovered to the point of being able to walk very short distances. But her appetite did not recover. I was then given a choice of traditional cancer therapy or hospice. In shock and disbelief, I reached out to Citizen's for Better Care, a Michigan advocacy group. They declined citing assisting with hospice is not part of their mandate. I subsequently chose a hospice with wide name recognition. It is the most regrettable decision I have ever made. My mother suffered tremendously with the hip fracture, surgery and struggle to walk again. I wanted her final months, weeks, days and hours to be as comfortable as humanly possible. Quite to the contrary, her "caregivers" failed to spend the extended time required by a very ill individual to feed and drink, they failed to change bedsore dressings as required, they failed to provide adequate pain medication to a terminal patient, they failed to keep patient clean and dry to not exacerbate hip-sacrum bedsores, and failed to provide and apply other medical supplies.

As a legal guardian, primary caregiver and daughter, I attended care conferences, every 3 months, in an attempt to ensure proper medical and overall care. When care was appropriate, I responded by an appropriate letter of thanks, but I wrote several letters of complaint to the nursing home administrator and hospice regarding inadequate, substandard care. Not a single letter was ever responded to. These formal letters of complaint were always follow-ups to personal verbal ones. I was overwhelmed between the stress, anxiety and worry about my mother's well-being and dealing with the nursing home and hospice. I struggled with the mental anguish of should I move my mother to another facility and deal with the devils I did not know versus the devils I knew. Consequently, both the nursing home and hospice had ample opportunity to do as they wished, since I reside outside US. This did not compromise my visits, which were at least weekly or more. So where did I go wrong? I still had faith in the human spirit of 2 institutions, where profit, deceit and greed prevails.

I now know the hospice choice should never have been like what my mother experienced. Hospice is intended to be the compassionate medical and spiritual care for the terminally ill. The patient's terminal disease is not treated, but it is my understanding that every human effort is to be made to ensure a pain free quality of life. In my opinion, with photographs to support this, the nursing home failed to provide even the most basic humane care and the hospice was not far behind. Hospice RN failed to attend my dying mother. (Hospice does not provide on site support on National Holidays.)

After my mother's death, I dealt with the shock, sorrow and grief. But, I soon realized that the circumstances of my mother's suffering and death were not normal, as hospice explained. I then began my quest to find answers. Sadly, my efforts to find justice for my mother, over the past 2 years have proved to be a nightmare. I learned elder neglect and abuse is a disgraceful reality in the United States. Many of the agencies entrusted to monitor and regulate the care of the elderly and infirm,

more oft than not, turn a blind eye. It is a fact that 1/3 of all US nursing homes have been cited for substandard care, neglect and/or abuse.

I have sent letters of complaint to 5 US Senators, 16 Mich. Congressman, 1 State Senator, 2 State Representatives, HCFA, US-GAO, US Attorney, Medicare Trust Solutions, Mich. Attorney General, Mich. Fraud Control Unit, Mich. Dept. of Health, (Nursing Homes, Nursing Home Administrator, Hospice &, Nursing Board divisions), Office of Inspector General, Centers for Medicare & Medicaid, Wayne County Sheriff's Office, JCAHO, Mich. Peer Review Org., local and national hospice organizations. I have also sent letters of complaint to advocacy groups including Mich. LTC Ombudsman, Mich. Campaign for Quality Care, Citizens for Better Care, Elder Justice Coalition, Judicial Watch, and AARP. Thus, 2 years and approximately 150 letters later, what have I accomplished? 1 US Congressman and 1 Mich. State Rep. has responded in a sympathetic manner. The vast majority of offices, agencies (some of whom are former nursing home employees) and individuals listed above have ignored, declined or denied my complaints.

The State of Michigan has substantiated: 1) Hospice CENA negligence resulting in patient injury, 2) Inadequate Hospice CENA support and 3) No Volunteer Hospice to aid patient required by law. The State of Michigan refused to investigate the nursing home, inaccurately citing statute of limitations. The State and Centers for Medicare & Medicaid has refused to accept any family proof of elder neglect, regarding allegations made. So, what does this mean? The nursing home has not been held accountable and the hospice needs only to provide a revised patient care plan.

It is my hope that this will encourage many of you to speak out for humane elder care. Even in difficult times, when you fight back, you assert your independence, win the occasional fight, and slow down the other side. Resistance represents a crucial step in keeping certain ideals alive. What we do or fail to do now will create the future standard of elder care that we will ultimately experience. Finally, we are building monuments to our mothers every day. The way we live determines how tall they will be.

## THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

March 3, 2003

**21<sup>st</sup> CENTURY MEDICARE: MORE CHOICES—BETTER BENEFITS****A FRAMEWORK TO MODERNIZE AND IMPROVE MEDICARE**

*“Seniors happy with the current Medicare system should be able to keep their coverage just the way it is. And just like you, the Members of Congress, members of your staffs, and other federal employees, all seniors should have the choice of a health care plan that provides prescription drugs. My budget will commit an additional 400 billion dollars over the next decade to reform and strengthen Medicare—I urge the members of this new Congress to act this year.”*

President George W. Bush, State of the Union, January 2003

**I. EXECUTIVE SUMMARY**

Since Medicare was enacted in 1965, it has provided health care security to millions of America’s seniors and people with disabilities. Medicare is the binding commitment of a caring society to our most vulnerable citizens, and a commitment that America must always keep.

As successful as the Medicare program has been, it has not always kept pace with decades of dramatic improvements in health care. As a result, Medicare beneficiaries today lack many of the choices and benefits available to millions of other Americans. Medicare still does not provide an outpatient prescription drug benefit, forcing many seniors to go without the medicines they need. Medicare does not provide full coverage for important preventive health care, such as cancer or diabetes screenings, and it does not offer protection against uncapped medical costs that can rob seniors of their savings.

Moreover, with health care costs on the rise and the Baby Boom generation nearing retirement, Medicare faces serious financial challenges. This will require Medicare to make the best use of today’s modern health care delivery methods to maximize the benefits for current and future participants while addressing the long-term sustainability of the program.

President Bush believes our nation has a moral obligation to fulfill Medicare’s promise of health care security for America’s seniors and people with disabilities. To meet this obligation, the nation must act now to bring Medicare into the 21<sup>st</sup> Century by providing more choices and better benefits to every senior in America.

In July 2001, the President outlined the following principles for Medicare reform:



1. All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.
2. Modernized Medicare should provide better coverage for preventive care and serious illness.
3. Beneficiaries should have the option of keeping the traditional plan with no changes.
4. Medicare should provide better health insurance options, like those available to all federal employees.
5. Medicare legislation should strengthen the program's long-term financial security.
6. The management of the government Medicare plan should be strengthened so that it can provide better care for seniors.
7. Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.
8. Medicare should encourage high-quality health care for seniors.

The President today is proposing a Framework to Modernize and Improve Medicare that builds on these principles. He looks forward to working with Congress on legislation this year to bring more choices and better benefits to Medicare. The President has committed up to \$400 billion over the next ten years in his FY 2004 budget to pay for modernizing and improving Medicare.

The President's framework will give all Medicare beneficiaries access to:

- **Prescription drug coverage** that enables seniors to get the medicines they need, without the government dictating their drug choices.
- **Choice of an individual health care plan that best fits their needs**—just like Members of Congress and other federal employees enjoy today.
- **Choice of the doctor, hospital, or place** they want for the treatment and care they need.
- **Full coverage for disease prevention** such as screenings for cancer, diabetes and osteoporosis.
- **Protection from high out-of-pocket costs** that threaten to rob seniors of their savings.

The President will make sure that low-income seniors receive additional financial assistance so they will not have to pay more to receive better benefits than they currently do under Medicare.

For too long, political pressures have kept our nation from bringing the benefits of modern health care to Medicare. The President is calling upon members of both political parties to work together with him to pass legislation this year.

### **More Choices—Including the Choice to Stay in Traditional Medicare**

The President believes Medicare beneficiaries should be given more choices in how they receive their health care—and these choices should be strictly voluntary.

Those seniors who are happy with their current coverage in traditional Medicare will be able to keep that coverage and receive help with the high costs of prescription drugs. **Traditional Medicare will continue to be there for those who want it with help for prescription drugs.**

But seniors who want more choices and better benefits—including a prescription drug benefit, full coverage of preventive care and limits on high out-of-pocket costs—will be able to select options providing these additional benefits as well. Seniors will have the right to select the health plan that fits their needs best—rather than a one-size-fits-all government plan.

## **Better Benefits—Including Prescription Drug Coverage**

### **Option 1—Traditional Medicare**

Those who are satisfied with the current Medicare system will continue receiving their care as they do today with help for the high costs of prescription drugs. These beneficiaries will gain access to discounted drugs through a prescription drug discount card—estimated to achieve savings of 10-25% on the cost of prescription drugs—as well as coverage to protect them against high out-of-pocket prescription drug expenses. These new benefits will be provided at no additional premium.

### **Option 2—Enhanced Medicare**

Enhanced Medicare will give seniors the same types of choices that are available to members of Congress and other federal employees. In every area of the country, Medicare beneficiaries will have multiple health plans from which to choose. These plans will offer prescription drug benefits, full coverage of preventive benefits, protection against high out-of-pocket drug costs, and cost sharing that does not penalize participants who need the most medical care. Again, the decision to choose Enhanced Medicare will be entirely up to each senior, and participants will be able to choose any doctor or any hospital they want for the treatment and care they need.

The President's framework will ensure that the benefits offered under Enhanced Medicare are sufficiently attractive to seniors, relative to traditional Medicare, to guarantee that Enhanced Medicare is a viable system.

### **Option 3—Medicare Advantage**

Seniors will also have the option of enrolling in low-cost and high-coverage managed care plans, similar to those available today under Medicare. Medicare Advantage will include plans that offer a subsidized drug benefit, and all plans will be able to offer extra benefits, as many private plans do today.

## **Immediate Discounts for all Seniors**

To ensure that seniors are provided help as soon as possible, the President will ask Congress to immediately provide all seniors with a drug discount card that is estimated to achieve savings of 10 to 25 percent on the cost of prescription drugs by pooling the buying power of Medicare participants.

## **Additional Help for Low-Income Seniors**

Under the President's framework, low-income Medicare beneficiaries will get prescription drug coverage without paying additional premiums and will receive additional assistance with their cost-sharing. The President will ask Congress to provide low-income seniors immediately with a prescription drug discount card, as well as a \$600 annual subsidy for drug coverage, which will continue for low-income seniors who stay in traditional Medicare. This subsidy can be added to their discount card at the point of sale, or alternatively paid to existing Medicare Choice health plans that enroll low-income seniors and provide them with prescription drug coverage.

**II. A FRAMEWORK TO MODERNIZE AND IMPROVE MEDICARE**

**Background**

Since Medicare was enacted in 1965, it has provided health care security to millions of America’s seniors and people with disabilities. The program was established using the most current insurance models of its day and has proven successful in extending coverage to some of society’s most vulnerable members. Today, Medicare provides health care coverage for 40 million Americans. Enrollment is expected to reach 77 million by 2031, when the Baby Boom generation is fully enrolled.

As successful as Medicare has been, it has not kept pace with decades of dramatic improvements in health care delivery. As a result, Medicare today does not provide the benefits and choices that are available to many other Americans. The program lacks an outpatient prescription drug benefit, full coverage of many preventive benefits, and protection from high out-of-pocket costs.

Medicare’s current hospital coverage illustrates the need to update the program. Instead of providing more coverage for patients when they get sick and go into the hospital, Medicare actually requires them to pay more when they need to stay longer in a hospital. This is just the opposite of what Americans in most private health plans experience today.

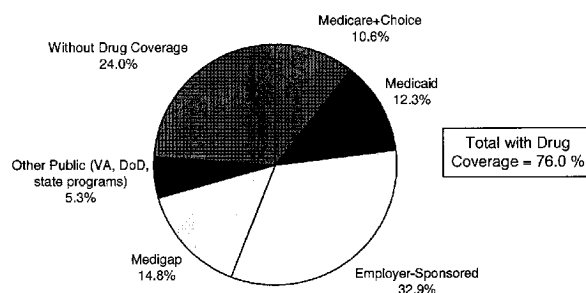
**Current Medicare and Sample Federal Employee Cost-Sharing Requirements for Inpatient Hospital Care**

<b>Participant Pays</b>		
<b>Hospital Stay</b>	<b>Current Medicare</b>	<b>Standard Blue Cross/Blue Shield Plan for Federal Employees</b>
Days 1-60	\$840 per admission	\$100 co-payment per admission
Days 61-90	\$210 per day	\$0 per day
Days 91-150	\$420 per day	\$0 per day
Over 150 Days	<u>All</u> Costs	\$0 per day

Many participants in Medicare bolster their Medicare coverage with supplemental policies (Medigap) or retiree health insurance. Some seniors—those with the lowest incomes—are eligible for coverage from Medicaid. But many seniors do not have access to affordable supplemental assistance, leaving them vulnerable to the high costs of serious illness.

Twenty-four percent of Medicare participants lack any drug coverage, millions more have very limited drug coverage, and many cannot afford the drugs they need to maintain their health and prevent serious illness (see below).

**Percent of Medicare Beneficiaries with Drug Coverage, by Source of Coverage (2002 Projection)**



SOURCE: CMS analysis of the non-institutionalized Medicare population.

Absent substantial reform of the Medicare program, the situation is certain to worsen. Premiums for Medigap plans, particularly those with drug coverage, have increased considerably over the past three years and are often unaffordable for participants of modest means. At the same time, employers find it increasingly difficult to fund retiree health care, and many have reduced or eliminated these benefits.

To ensure that Medicare provides a secure health care future for today's seniors and future retirees, the nation must act now to modernize and improve the program. The President has committed up to \$400 billion over the next ten years to pay for modernizing Medicare, and looks forward to working with Congress to develop and pass legislation this year.

President Bush's framework will give all Medicare beneficiaries access to:

- **Prescription drug coverage** that enables seniors to get the medicines they need, without the government dictating their drug choices.
- **Choice of an individual health care plan that best fits their needs**—just like Members of Congress and other federal employees enjoy.
- **Choice of the doctor, hospital, or place** they want for the treatment and care they need.

- **Full coverage for disease prevention** such as screenings for cancer, diabetes and osteoporosis.
- **Protection from high out-of-pocket costs** that threaten to rob seniors of their savings.

### **More Choices—Including the Choice to Stay in Traditional Medicare**

A key part of modernizing and improving Medicare is adding flexibility to the program so that Medicare participants have the right to more choices in how they receive their care—including the choice of staying exactly where they are today.

Those who have coverage they value in traditional Medicare will be able to keep that coverage and receive help paying for the high cost of prescription drugs. **Traditional Medicare will continue to be there for those who want it with help for prescription drug costs.**

But seniors who want to have more choices and better benefits—including a comprehensive prescription drug benefit, full coverage of preventive care and limits on high out-of-pocket costs—will have that choice as well. They will be able to enjoy the same types of choices that members of Congress and other federal employees do.

If Congress passes legislation this year, then these choices will be available beginning January 1, 2006. In the meantime, to give seniors more immediate help with prescription drugs, the President is proposing to make a prescription drug discount card available to all seniors and to provide an additional \$600 subsidy to low-income participants for their prescription drug costs.

### **Better Benefits—Including Prescription Drug Coverage**

#### **Option 1—Traditional Medicare**

Seniors currently enrolled in traditional Medicare could continue receiving their care as they do today through the current benefit structure with additional help for the high cost of prescription drugs. Part B premiums for participants in traditional Medicare would not be affected by the creation of Enhanced Medicare.

Additionally, beneficiaries remaining in traditional Medicare will be able to receive coverage to protect them against high out-of-pocket prescription drug expenses, at no additional premium. They can also choose to receive a drug discount card like all seniors.

Participants who are satisfied with their current coverage could also continue receiving coverage from supplemental sources, including former employers, Medigap or Medicaid. The President's framework will add two new Medigap plans to the existing ten standardized plans. These new plans will include prescription drug assistance, additional protection against high out-of-pocket costs, and would reduce, but not eliminate, deductibles and co-payments.

## Option 2—Enhanced Medicare

Under Enhanced Medicare, seniors will receive a choice of plans similar to those offered to federal employees and members of Congress through the Federal Employees Health Benefit Plan (FEHBP). The choice of plans would be available to all seniors regardless of where they live. Enhanced Medicare will offer benefits described below and standard drug coverage (or an equivalent benefit package). As with traditional Medicare, the federal government will pay for most of the cost of coverage under Enhanced Medicare, with participants paying a smaller share. Beneficiaries who enroll in an average priced plan in their region would pay a premium for the medical portion of their coverage equal to the Part B premium.

Under Enhanced Medicare, seniors will be able to choose any doctor, any hospital, in any place for the treatment and care they need. Additionally, Enhanced Medicare plans will offer seniors the option of further limiting their out-of-pocket costs through supplemental coverage.

### Enhanced Medicare will include the following benefits:

- **Prescription Drug Coverage:** Under Enhanced Medicare, plans will offer a subsidized prescription drug benefit with a monthly premium, an annual deductible, coverage of prescription drug costs and protections for those who have high drug costs. Low-income seniors will receive this drug coverage for no additional premium and will receive additional subsidies to limit their copayments.

To provide an array of choices in benefit design and to encourage plan innovation, plans will be free to structure their offerings differently, provided the benefit meets a basic federal standard. Further, plans will be required to show that any changes they make to the standard benefit package are not meant to attract only healthy enrollees or discourage the sick or people with disabilities from joining.

- **Full Coverage of Preventive Benefits:** Currently, Medicare covers certain preventive services only after the Part B deductible is met. In addition, many preventive services require co-insurance. Enhanced Medicare plans will provide full coverage of preventive services. Full coverage will remove the financial barriers for low-income seniors, who are less likely to seek preventive treatment, such as prostate cancer screenings and mammographies.
- **Protection from High Out-of-Pocket Costs:** Traditional Medicare does not protect patients from uncapped costs. Enhanced Medicare will eliminate the lifetime limit for inpatient hospital care and protect against high medical bills for hospitalizations. In Enhanced Medicare, participants with very high out-of-pocket costs will face no additional cost sharing. Traditional Medicare does not limit these costs.
- **Fairer Cost Sharing:** Currently, traditional Medicare penalizes its sickest participants by requiring them to pay more when they need to stay longer in a hospital. At the same time, Medicare requires cost-sharing for some services, but not for others. For example,

patients pay 20 percent or more when they visit their doctor or a hospital outpatient department, but those needing home health care pay nothing out-of-pocket.

Under Enhanced Medicare, participants will have a single deductible for medical services, like that in most private insurance plans, to provide better protection from high expenses for all types of health care. The single deductible will replace the separate Part A and Part B deductibles. Additionally, after a lower deductible, participants would pay nothing for their first two inpatient hospital admissions in a year and a reasonable copay for any subsequent admission. These changes will provide better protection for participants who need the most medical care. Further, Enhanced Medicare will have sensible cost-sharing requirements on all other services, including limits on out-of-network cost sharing.

#### **Assistance for Low-Income Seniors in Enhanced Medicare**

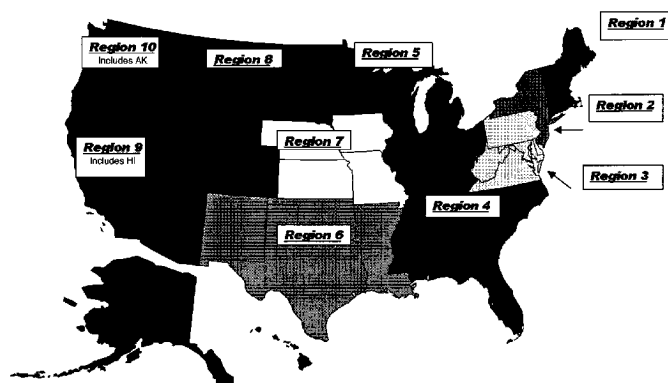
Under Enhanced Medicare, low-income participants who are not eligible for Medicaid will receive financial assistance with out-of-pocket prescription drug costs. Lowest income participants will pay no drug premiums or deductibles and will pay only nominal cost sharing, regardless of their level of out-of-pocket spending. States would determine eligibility for low-income assistance.

#### **Administration of Enhanced Medicare**

Enhanced Medicare will be administered by a new Medicare Center for Beneficiary Choices (MCBC) under the Department of Health and Human Services.

The MCBC will designate large, multi-state Medicare regions. In each region, seniors and people with disabilities will have several Enhanced Medicare options. The chart below illustrates one way in which these large, multi-state regions might be structured.

**Enhanced Medicare Sample Regions**



Plans will submit bids to the MCBC for the opportunity to serve one or more of the Medicare regions, and plans will have to accept any Medicare participant wishing to enroll regardless of whether the beneficiary lives in a rural or remote area. This approach minimizes risk selection and guarantees access for all seniors to these plans, as is the case with the Federal Employees Health Benefit Program.

**Option 3—Medicare Advantage**

In addition to Enhanced Medicare, seniors will have the option of enrolling in the same type of low-cost and high-coverage managed care plans that are available today under Medicare. Currently 5 million Medicare participants choose to get their benefits and receive additional services from such plans. These plans often offer broader coverage at a lower cost than the combination of Medicare and Medigap plans that many seniors choose.

Under the newly created Medicare Advantage program, plans in competitive markets will bid to provide participants with Medicare's enhanced basic benefit package. Participants who select more efficient plans will benefit from savings, and some participants in the most efficient plans could pay no premium at all and potentially qualify for a rebate on their premium.

Advantage plans will continue to be a good choice for participants willing to accept a more selective provider panel in exchange for lower cost sharing and extra benefits. Creating a system in which different types of delivery systems compete for participants' business will result in a marketplace where plans in each system will have strong incentives to provide the most efficient



and highest quality care. Efficient plans will be able to offer extra benefits and/or reduced cost sharing.

Advantage Plans will also be able to offer a benefits package without drugs for those participants who are satisfied with drug coverage they already have. Just as in Enhanced Medicare, low-income seniors will pay no additional cost for a drug benefit offered through Medicare Advantage plans. Other enrollees will pay a monthly premium to pay for their share of the prescription drug benefit costs.

### **Immediate Discounts for all Seniors**

A Medicare-endorsed prescription drug discount card will provide an opportunity for all seniors to get discounted drugs as Medicare transitions to a modernized system. All participants, for a nominal enrollment fee (waived for low-income seniors), will be able to join a discount card plan. The card will let them pool their buying power with that of other participants to obtain manufacturers' discounts, with savings from 10 to 25 percent. No longer will uninsured seniors face the highest retail prices of any group. In addition, drug card sponsors, which could include Pharmacy Benefit Managers and other entities, will publish comparative information on drug prices to help seniors make smart buying choices.

### **Additional Help for Low-income seniors**

Under the President's framework, low-income seniors who enroll in Enhanced Medicare will get prescription drug coverage without paying additional premiums and will receive additional assistance with their cost-sharing for prescription drugs. Like all seniors, they will be eligible to receive immediately a Medicare drug discount card, at no cost, which would provide them with estimated savings of 10 to 25 percent on the price of prescription drugs. In addition, low-income seniors will receive an added subsidy of \$600 annually to pay for prescription drugs. The subsidy will be added to their discount card and work like other federal electronic benefit transfer programs, with the card providing the subsidy at the point of sale. The subsidy could alternatively be paid to existing Medicare+Choice plans that enroll low-income seniors and provide them with prescription drug coverage.

### **SUMMARY**

The President's framework for Medicare will provide more choices and better benefits for all seniors. If legislation is passed in 2003, then beginning next year, seniors will have the following benefits:

In 2004: All seniors will receive access to discounted drugs (discount of 10-25%) through Medicare-endorsed prescription drug discount cards.

All low-income seniors will have access to drug discounts through the card, and an additional \$600 per year to assist in purchasing prescription drugs.

In 2006: Seniors will have the option of staying in Traditional Medicare and receiving a prescription drug discount card, coupled with coverage that would protect them against high out-of-pocket costs for their prescription medicines.

All seniors will have access to at least three new Enhanced Medicare plans that offer:

- comprehensive prescription drug coverage;
- full coverage of preventive care; and
- protection against high out-of-pocket medical costs.

Seniors will still have the option of choosing a Medicare Advantage plan that will offer prescription drug coverage and other benefits in a managed care setting.

### **Conclusion: Medicare for Today and Tomorrow**

President Bush is committed to ensuring that Medicare will always be there for seniors and people with disabilities. His ideas for modernizing and improving Medicare build on the strengths and successes of the current system, while guaranteeing that all seniors will have access to a prescription drug benefit and other benefits Medicare does not offer today. Under the President's framework for Medicare, seniors will have the right to the same type of health care benefits enjoyed by members of Congress and other employees of the federal government. Low-income seniors will not pay more for additional benefits.

To improve, Medicare must have the benefit of modern health care delivery systems and methods that have proven successful in the private sector. The President's initiative will introduce private sector innovation and competition to the Medicare system to help keep costs reasonable, ensure high quality care and begin to address Medicare's long-term financial challenges.

While Medicare must be modernized and improved to meet the needs of its current participants, the program must also be made sustainable for future generations. Given the financial challenges Medicare faces in the future, changes to the Medicare program we make today must not exceed our nation's means to deliver them tomorrow.

Seniors have waited too long for a modernized Medicare with a prescription drug benefit. It is time for members of both political parties to work together to pass legislation this year that will modernize and improve Medicare for seniors today and tomorrow.

