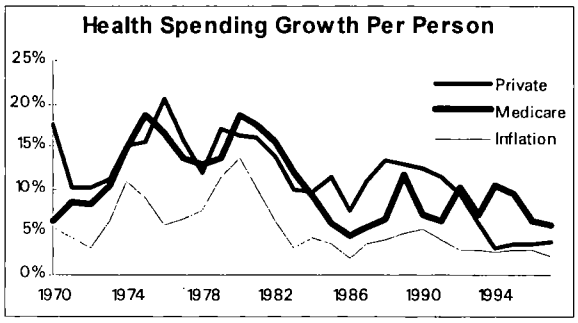
PRESIDENT'S FRAMEWORK FOR STRENGTHENING MEDICARE FOR THE 21st CENTURY

DRAFT: March 15, 1999

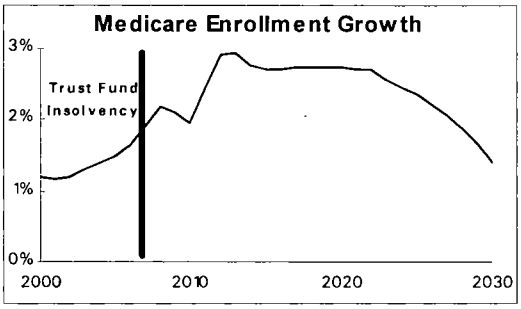
MEDICARE'S PROBLEMS ARE LARGE -- AND SOONER THAN THOSE OF SOCIAL SECURITY

- **Impending "senior boom".** Like Social Security, Medicare enrollment will double between 1999 (39 million) and 2032 (78 million) as the baby boom generation retires. Not only will there be more elderly in the future, but the elderly will live up to 6 years longer on average by the middle of the next century.

- **Additional challenges of health care.** Compounding the demographic challenges are the unique factors that affect health spending -- changing disease patterns, technological advances, and a high value placed on health. For example, the improved ability to prevent and cure diseases, while making tremendous improvements in the nation's health, has also driven up costs. As a result, health spending growth has historically exceeded that of general inflation. These trends are expected to continue into the next century. Private health spending growth per person is projected to be 7.3 percent between 1999 and 2007 -- more than twice as high as general inflation.



- **Improved but still large Trust Fund problem.** In 1993 when President Clinton took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be exhausted in 1999. Today, it is projected to be solvent for the next ten years. This is due to the historic changes in the Balanced Budget Act of 1997, aggressive efforts to reduce Medicare fraud and the general health of the economy.



- **Medicare spending outstrips income.** Despite these improvements, Medicare is spending more than its annual income from payroll taxes and other sources. As such, it has begun to use up its assets -- as the baby boom generation begins to retire, these assets will be gone. Although Medicare's prognosis in the Trustees' 1999 report will almost inevitably be better due to strong revenues and continued low spending, the fact remains: current income sources will not be able to finance health care services for the baby boom generation.

- **Over $1 trillion shortfall by 2020.** Once Medicare's Part A Trust Fund runs out of money, it will have to borrow money -- with interest -- to pay for services. The annual shortfall in income plus this interest will build to over $1 trillion by 2020. Also, Medicare's Part B services are growing rapidly, causing the automatic premium increases and general revenue contribution to rise.

OPTIONS FOR ADDRESSING MEDICARE'S LONG-TERM SOLVENCY: A wide range of ideas have been considered to help solve Medicare's fiscal imbalance. These can be categorized as:

- **Reducing provider payments and increasing efficiency**
- **Eliminating or limiting benefits covered**
- **Increasing beneficiary contributions to Medicare** and/or
- **Adding new revenue to Medicare**

1. Reducing Provider Payments and Increasing Efficiency

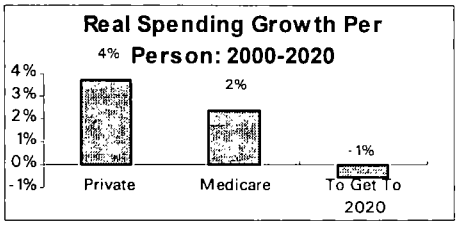
Improving Medicare's efficiency and competitiveness and reducing its overpayments and fraud are the focus of most efforts to strengthen Medicare's financial situation.

- **Strong gains in reducing Medicare spending.** Working with Congress, this Administration has reigned in Medicare spending growth. Since 1992, overpayments to health care providers have been reduced, important preventive benefits have been added, and payment systems for services like skilled nursing facilities and managed care have been modernized. Additionally, aggressive efforts to reduce fraud have saved the government billions. As a result, Medicare spending growth per beneficiary is projected to grow at 5.8 percent between 2000 and 2020 -- compared to an average rate of 10.8 percent between 1970 and 1996.

- **Provider payment reductions and improved efficiency alone cannot solve Medicare's long-term problems.** Adopting effective management tools and reducing overpayments undoubtedly contributes towards Medicare long-term solvency. However, by themselves, they cannot solve this problem. if reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be constrained to 2.8 percent per year -- in every year -- to get to 2020. To put this rate into perspective:

  - Medicare growth would have to be over 60 percent below projected private health insurance spending per person (7.3 percent). By 2020, a growth rate of 2.8 percent per beneficiary would result in Medicare spending that is over 40 percent below what is projected to be under current law.

  - This growth rate is about 1 percent below inflation according to the Trustees, reducing the value of Medicare spending per beneficiary over time. By 2020, Medicare's spending would be 10 percent below today's level.



2. Eliminating or Limiting Benefits Covered by Medicare

A second option for addressing Medicare's long-term solvency is to reduce its benefits (e.g., limit coverage for home health care services; eliminate coverage of skilled nursing facility care).

- **Today, Medicare benefits are sub-standard.** Medicare benefits were designed in 1965 to be similar to those offered by the private sector. Since then, however, Medicare benefits have not kept pace with changes, so that Medicare is now less generous than 80 percent of large employer's health insurance plans.

- **Medicare does not cover prescription drugs**. Drugs have become an essential part of modern medicine, yet 13 million beneficiaries have no health insurance coverage, and millions more have inadequate or unstable coverage.

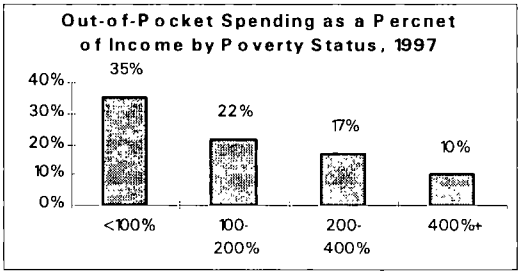
- **Without other changes, only removing major, critical services could keep Medicare solvent in the long-run** Although Medicare already has a limited benefits package, limiting it even more would not solve its long-term problems. Even removing all skilled nursing facility plus hospice spending or all graduate medical education and disproportionate share hospital spending from Medicare would not be enough to extend its solvency to 2020.

3. Increasing Beneficiary Contributions to Medicare

A third option for addressing Medicare's long-term financing problem is to have beneficiaries pay for more of the cost of health care.

- **Beneficiaries already pay for almost half of their health care costs**. Because of its less generous benefits and higher cost sharing, Medicare only pays 52 percent of the total health care costs of its beneficiaries.

- **Low-income and sick beneficiaries are particularly vulnerable to cost increases.** Despite Medicaid coverage of Medicare premiums and cost sharing for most poor beneficiaries, out-of-pocket health spending consumers over one-third of poor beneficiaries' income.



- **Relying on beneficiaries alone to solve the financing gap would increase Medicare premiums by 75 percent.** A $37 premium per month on top of the current premium would be needed to equal the amount transferred from the surplus in 2000 under the President's proposal. This would be about $890 a year for an elderly couple.

4. Adding New Revenue to Medicare

The fourth and final option is adding new revenue to Medicare to assure that its services are adequately funded in the next century. Unlike the previous options, adding new revenues does not change Medicare spending. Instead, it fills in the inevitable, remaining shortfall after some combination of the other options have reduced Medicare spending as much as possible.

- **Increasing the Medicare payroll tax would mean that all workers -- including younger and lower wage workers -- would pay for the shortfall**. Without reducing Medicare spending, nearly a 20 percent increase in the payroll tax for both employees and employers would be needed (from 2.9 to 3.4 percent combined) to fund Medicare through 2020. This includes the 60 million American workers who earn less than $30,000 in income (check).

- **Waiting shifts the burden to our children**. If funds aren't immediately added to the Medicare Trust Fund, its assets will continue to be used up, making size of the problem even larger. More importantly, it means that the larger taxes that would be needed would <u>not</u> come from the baby boomers --who will be retiring -- but from their children.

THE PRESIDENT'S FRAMEWORK FOR MEDICARE REFORM

In his State of the Union speech, the President outlined his framework for Medicare: improve Medicare's financial outlook by dedicating 15 percent of the surplus to its depleted Trust Fund, and enact broader reforms including the addition of a long-overdue prescription drug benefit.

Dedicate Part of the Surplus to Secure Medicare. The President's proposal would transfer 15 percent of the projected unified budget surplus to the Medicare Hospital Insurance (HI) Trust Fund for the next 15 years (2000 through 2014). This amount would equal $686 billion over the period ($120 billion in the next 5 years).

- **Trust Fund solvency for at least another decade.** This early investment in the Medicare Trust Fund prevents it from being used up and allows it to generate income. This has the effect of adequately funding Medicare for at least another decade.

- **Surplus locked into Trust Fund**: Under this proposal, the Treasury would transfer the annual amount of funds to the Medicare Trust Fund. This amount would no longer be considered part of the unified budget surplus. Once these funds are transferred, they would be treated the same way as other HI Trust Fund assets. As such, they would be invested and generate interest income for the Trust Fund to the extent that they are not needed to pay for services. If there is not enough Trust Fund income to pay for HI expenditures, these funds, indistinguishable from other Trust Fund assets, would be redeemed to pay for that shortfall.

- **Investing now prevents larger problem later.** Even though the Medicare shortfall is projected to accumulate to over $1 trillion by 2020, the President's $686 billion investment can fill this hole because it is invested early, earns interest, and prevents Medicare from having to borrow to pay for services.

- **One-time, fixed contribution**. The President's proposal does not create an unlimited tap on general revenue for Medicare. Instead, it takes a fixed proportion of the surplus -- in large part created by the baby boom generation -- and invests it in Medicare to pay for the services when this generation retires. As such, it is similar to pre-funding: putting aside the extra revenues from the strong economy to pay for the temporary but overwhelming influx of retirees beginning in 2010.

Modernize Medicare and Make It More Competitive.

- **Commitment to strengthening Medicare's competitiveness.** The President has proposed many policies that would give Medicare the same tools that the private sector uses to control costs. Although Congress has not passed all of them, he is committed to review the recommendations of the Medicare Commission. He also is committed to working with Congress on policies to adopt the best management, payment, clinical and competitive practices used by the private sector, to help maintain high-quality services and keep spending growth in line with the private spending.

Guarantee Defined Set of Benefits Without Excessive New Costs to Beneficiaries.

- **Strong, modernized defined benefits must be assured.** As reform proposals are considered by Congress, the President will evaluate them to assure that beneficiaries are entitled to an adequate set of health benefits. A modernized, well-defined benefits package is needed to assure that health plans compete on cost and quality rather than price. Proposals should also maintain or strengthen protections for low-income beneficiaries, assure that any new cost burdens are not excessive, and assure that beneficiaries have access to a viable traditional Medicare program.

Use Savings from Proposals to Help Fund a Prescription Drug Benefit.

- **Prescription drugs are an essential part of modern medicine.** Prescription drugs have become an essential part of treatments and cures, and are expected to play an even greater role in health care in the next century. Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children.

- **Medicare does not cover prescription drugs.** About 13 million beneficiaries have no insurance coverage for drugs whatsoever, and millions more have unstable, inadequate or expensive coverage. Lack of coverage can hurt beneficiaries' health. One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their drug coverage was limited.

- **Proposals to address Medicare's challenges should include a meaningful, affordable drug benefit for all beneficiaries.** The President believes that any legislation to prepare Medicare for the challenges of the next century must include coverage of prescription drugs. This coverage should be available to all beneficiaries, regardless of where they live or whether they are in a managed care plan. It should be affordable, with a large enough government contribution to the cost of the coverage to assure that all beneficiaries can afford the option. And it should designed and managed in a way comparable to private managed care plan coverage.

- **Paid for in the context of broader reforms.** A well-designed prescription drug benefit for Medicare could be financed in a comprehensive legislative package that both reduces spending through competition and aggressive purchasing and increases financing through dedication of funds from the surplus. The President believes that re-investing Medicare savings in this benefit will have a long-run effect of improving the medical management of Medicare beneficiaries, especially those with chronic illness, and reducing costs associated with underuse of critical drugs (e.g., unnecessary hospitalizations, complications). Adding this benefit would not detracting from the President's goal of making Medicare stable and solvent for another decade.

OMB Document

Medicare Prescription Drug Benefit

Potential Savings to the Program. Numerous studies have evaluated the possible savings realized by the Medicare program with the implementation of a monitored (i.e., including drug utilization review and physician education) outpatient prescription drug benefit. Studies have reported savings from reductions in inpatient volume, reductions in nursing home, home health and partial hospitalization services, and savings from the avoidance of hospitalizations and readmissions due to adverse drug reactions.

A report done in 1994 by the Lewin-VHI, Inc. estimated that the use of cost-effective pharmaceuticals, the more appropriate use of pharmaceutical products and diffusion of advanced pharmacy services would save the Medicare program an estimated $29.2 billion between 1996 and 2000.[1]

Reductions in Inpatient Volume. Offering a drug benefit may decrease the volume of services, specifically inpatient admissions. One study reports that Medicare policy prohibiting coverage of outpatient, self-administered drugs has severely limited access of Medicare patients to ambulatory intravenous antibiotic therapy, thus forcing them to rely on more costly inpatient hospital care. This study tested the hypothesis that a new Medicare benefit providing coverage for ambulatory intravenous antibiotic therapy could significantly reduce the program's expenditures for the treatment of infectious diseases. The authors reported a cumulative 5-year savings of nearly $1.5 billion[2] associated with the new Medicare benefit.[3]

A study in *Health Economics* found that an increase of 100 prescriptions is associated with 16.3 fewer hospital days. A $1 increase in pharmaceutical expenditure is associated with a $3.65 reduction in hospital care expenditure (ignoring any indirect cost of hospitalization), but it may also be associated with a $1.54 increase in expenditure on ambulatory care.[4] Because outpatient costs are more often borne by the patients than are inpatient costs, this effect may result in costs for the patient and savings for the Medicare program.

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[1]Lewin-VHI (1994) *Savings from a Medicare Pharmaceutical Benefit,* pg. i

[2]Model results are predicted on the March 1997 CBO estimates of projected Medicare growth.

[3]Tice, AD., Poretz, D., Cook, F., Zinner, D., Strauss, MJ.: *Medicare Coverage of Outpatient Ambulatory Intravenous Antibiotic Therapy: A Program That Pays for Itself.* Clinical Infectious Diseases, 1998; 27(6): 1415-21.

[4]Lichtenberg, FR.: *Do (More and Better) Drugs Keep People Out of Hospitals.* Health Economics,

Case studies of a number of specific drugs have shown that these drugs reduced the demand for hospital care. According to the Boston Consulting Group, operations for peptic ulcers decreased from 97,000 in 1977, when H2 antagonists were introduced, to 19,000 in 1987; this is estimated to have saved $224 million in annual inpatient medical costs.[5] The recent Scandinavian Simvastatin Survival Study indicated that giving the drug simvastatin to heart patients reduced their hospital admissions by a third during five years of treatment. It also reduced the number of days that they had to spend in the hospital when they were admitted, and reduced their need for bypass surgery and angioplasty.[6]

Another study used clinical, economic, and epidemiologic data to compare the costs of conventional inpatient care of osteomyelitis, or inflamation of the bone, with the costs of early-discharge treatment using a once daily parenteral antibiotic at home. Osteomyelitis was the cause of 16,578 Medicare-reimbursed admissions in 1995, with a mean length of stay of 15.7 days.[7] Osteomyelitis was selected for study because a new once-daily cephalosporin antibiotic, cefonicid sodium, has been shown to be effective in treating osteomyelitis in the outpatient setting. The authors found that early-discharge treatment was associated with lower medical direct, non-medical direct, and indirect expenses than conventional inpatient treatment. Estimated savings per patient ranged from $510 to $22,232 (the wide differences in estimated savings are a result of the use of different sources of data on hospital costs).[8]

In a retrospective study of health care use among Medicare beneficiaries in New Jersey and eastern Pennsylvania, one study examined the impact of New Jersey's Pharmaceutical Assistance for the Aged (PAA) program on health care costs. This study found that New Jersey Medicare recipients used, on average, $238.50 less in inpatient hospital care under the PAA program than did their counterparts in eastern Pennsylvania, which did not have a drug payment assistance program in place. Although administrative costs may have reduced overall savings, the study concludes that the PAA program resulted in no overall health care cost increases.[9] In other words, the cost of the drugs and administering the benefit did not exceed the savings from reductions in inpatient utilization.

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[5]Boston Consulting Group.: *The Contribution of Pharmaceutical Companies: What's at Stake for America, Executive Summary.* Unpublished report, Boston Consulting Group, Inc., 1993.

[6]New York Times.: *Cholesterol Pill Linked to Lower Hospital Bills.* 27 March 1995a, p. A11.

[7]From the Medicare Provider Analysis and Review (MEDPAR) file of 1995, which contains hospital discharge data for all Medicare beneficiaries using inpatient hospital services.

[8]Eisenberg, JM., Kitz, DS.: *Savings from Outpatient Antibiotic Therapy for Osteomyelitis. Economic Analysis of a Therapeutic Strategy.* JAMA, 1986; 255(12): 1584-1588.

[9]Lingle, EW., Kirk, KW., Kelly WR.: *The Impact of Outpatient Drug Benefits on the Use and Cost of Health Care Services for the Elderly.* Inquiry, 1987; 24(3): 203-11.

Reductions in Nursing Home, Home Health and Partial Hospitalization Volume. The National Institute on Aging estimates that effective treatment for Alzheimer's victims, including the drug Tacrine, could keep 10 percent of patients out of nursing homes, thus savings billions of dollars.[10] One study examined the effects of limits on Medicaid payments for drug treatment and found that restrictions on access to anti-psychotic drugs, the most effective treatment for acute episodes or exacerbations of schizophrenic illness, caused a significant increase in visits to Community Mental Health Centers (CMHCs) and increases in the use of emergency mental health services, and partial hospitalizations.[11] Another study examined the effect of one state's limit of three Medicaid-reimbursed prescriptions per month and found that limiting reimbursement for effective drugs puts frail, low-income, elderly patients at increased risk of institutionalization in nursing homes (relative risk of admission to a nursing home of 2.2 and of admission to a hospital of 1.2 when access to drugs was restricted) and may increase Medicaid costs.[12]

Savings From More Appropriate Use of Pharmaceuticals. Pharmaceuticals sometimes lead to drug-induced disease and drug-related hospital admissions. Drug related hospitalizations (DRH) occur primarily as a result of adverse drug reactions (ADR), an unintended effect of a drug, and therapeutic failure, a failure of a drug due to non-compliance, dose reduction/discontinuation, interaction, improper prescribing, inadequate monitoring, etc. A managed Medicare drug benefit would use drug utilization review, along with other tools, to coordinate the benefit and decrease adverse drug reactions.

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[10]Rice, DP., Fox, PJ., Max, W., et. al.: *Economic Burden of Alzheimer's Disease Care.* Health Affairs, 1993; 12(2): 164-76.

[11]Soumerai, SB., McCLaughlin, TJ., Ross-Degnan, D., Casteris, CS., Bollini, P.: *Effects of Limited Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia.* The New England Journal of Medicine, 1994; 331: 650.

[12]Soumerai, SB., Ross-Degnan, D., Avorn, J., McLaughlin, TJ., Choodnovskiy, I., : *Effects of Medicaid Drug-Payment Limits on Admissions to Hospitals and Nursing Homes.* The New England Journal of Medicine, 1991; 325: 1072-1077.

A number of studies have attempted to assess the number of DRHs that occur and the percentage which are avoidable with increased drug management. One study which classified the geriatric admissions to a community hospital found that DRH accounted for 6.4 percent of all admissions among the over 65 population. The study estimated that 76 percent of these admissions were avoidable.[13] A similar study which examined admissions to six medical wards found that the prevalence of drug related hospital admissions caused by ADRs was 8.4 percent and 47 percent were deemed avoidable.[14] A third study which reported on interviews with 315 consecutive elderly patients admitted to acute care hospitals found that 16.8 percent of elderly admissions were due to ADRs.[15] A final study, with the objective of determining the excess length of stay, extra costs, and mortality attributable to ADRs in hospitalized patients, concluded that the attributable lengths of stay and costs of hospitalization for ADRs are substantial and that an ADR is associated with a significantly prolonged length of stay, increased economic burden, and an almost 2-fold increased risk of death.[16]

Hospital readmissions are another source of cost to the Medicare program. Approximately 22 percent to 36 percent of elderly patients are readmitted to the hospital within 6 months of their initial discharge. In addition, rehospitalizations account for 24 percent of all inpatient Medicare expenditures.[17] The findings of one study suggest that in half of the cases drug-related problems precipitated the readmission of the patient and that prevention of the problem could have precluded the readmission. Although the prevention of contributory drug-related problems might not eliminate a hospital readmission, it might decrease the length of stay and costs of the readmission, or improve the patient's discharge prognosis.[18]

Possible Management Tools.

Pharmacy Benefit Manager (PBMs). PBMs administer the prescription drug part of health insurance plans on behalf of plan sponsors, such as self-insured employers, insurance companies,

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[13]Bero, LA., Lipton, HL. and Bird, JA.: *Characterization of Geriatric Drug-Related Hospital Readmissions.* Med Care, 1991; 29 (10): 989-1003.

[14]Hallas, J., Gram, LF., Grodum, E., et. al.: *Drug Related Admissions to Medical Wards: A Population Based Survey.* British Journal of Clinical Pharmacology, 1992; 33(1): 61-68.

[15]Nananda, Col., Fanale, JE., Kronholm, P.: *The Role of Medication Noncompliance and Adverse Drug Reactions in Hospitalizations of the Elderly.* Arch Internal Medicine, 1990; 150: 841-845.

[16]Classen, DC., Pestotnik, SL., Evans, RS., Llyod, JF., Burke, JP.: *Adverse Drug Events in Hospitalized Patients. Excess Length of Stay, Extra Costs, and Attributable Mortality.* JAMA, 1997; 277(4): 301-306.

[17]ibid

[18]Bero, LA., Lipton, HL. and Bird, JA.: *Characterization of Geriatric Drug-Related Hospital Readmissions.* Med Care, 1991; 29 (10): 989-1003.

and health maintenance organizations. In their interviews, Grabowski and Mullins obtained estimates from the leading PBMs of the potential savings to the drug budget to payors, relative to an unmanaged plan, from PBM interventions designed to affect drug product selection. These activities (generic substitution, formularies, drug utilization review and prior authorization) can produce estimated savings between 14 and 31 percent in the health plans total expenditures[19]. The GAO studied three FEHBP plans that contracted with PBMs to control rapidly rising pharmacy benefit payments. The plans estimated that PBMs saved them over $600 million in 1995 by obtaining manufacturer and pharmacy discounts and managing drug utilization. These savings reduced the pharmacy benefit costs each plan believes it would have paid without using a PBM by between 20 and 27 percent.[20] Note that by using current spending levels in the MCBS data, utilization controls used by employers and other insurers were assumed in the last estimate. Therefore, these savings estimates may be higher than what Medicare could achieve.

Medicare would establish a process whereby PBMs in each region competitively bid to provide Medicare services. Once a contract is awarded, the winning PBM in each region would be the sole-source benefits manager for a beneficiary in that area.

The PBM could use any or all of the following techniques to manage the benefit plus selective contracting and competitive bidding.

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[19]Grabowski, H. and Mullins, D.:*Pharmacy Benefit Management, Cost-Effectiveness Analysis and Drug Formulary Decisions.* Social Science Medicine, 1997; 45 (4): 535-543.

[20]U.S. General Accounting Office : *FEHBP Plans Satisfied With Savings and Services, but Retail Pharmacies Have Concerns.* GAO/HEHS-97-47.

BACKGROUND ON PRESCRIPTION DRUGS

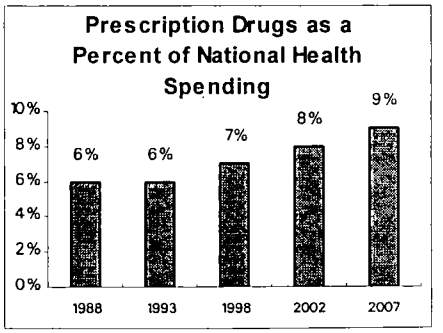
DRAFT: April 12, 1999

PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

- **Increasing reliance on drugs**. Prescription drugs have become an essential part of health care, and are expected to play an even greater role in the next century. They serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV/AIDS). Some of the major advances in public health -- the near eradication of polio and measles and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

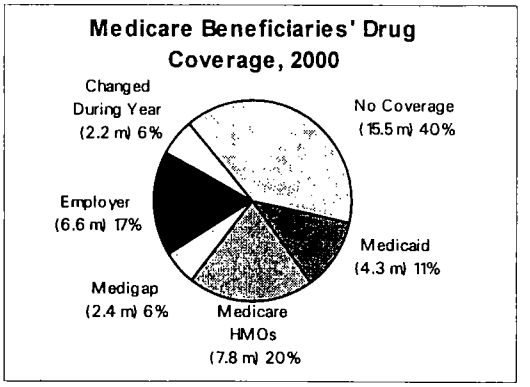
- **Elderly and people with disabilities rely more on prescription drugs**. Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. Although the elderly comprise 12 percent of the U.S. population, they account for over one-third of all prescription drug spending. The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication.

- **Rising share of national health spending**. The increased importance of prescription drugs is reflected in national health spending trends. In the past 10 years, spending on prescription drugs has risen as a percent of total spending by 20 percent. In the next 10 years, its share of national health spending is projected to increase by nearly 30 percent. This means that nearly one in ten health care dollars will be spent on drugs.



- **Drugs may reduce need for other services**. Studies have found that elderly, ill Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes. The increased cost of institutionalization exceeded the savings from reduced drug utilization by 20 fold. And, stroke patients treated promptly with drugs to thin clots had lower health care costs.

DRUG COVERAGE AMONG MEDICARE BENEFICIARIES



- **Private supplemental drug coverage is low and declining:** Only 23 percent of Medicare beneficiaries are expected to have private insurance for drug coverage (retiree coverage or Medigap) in 2000 (according to the Medicare actuary) -- down from 38 percent in 1995. Both sources of coverage have been declining rapidly as the cost of coverage rises and therefore cannot be relied upon to provide needed insurance in the future.

  - ***Retiree health insurance***: Employer-sponsored retiree insurance, the most generous type of drug coverage for beneficiaries, is an important but eroding source of coverage. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent. The Medicare actuaries project that, by 2000, only 17 percent of beneficiaries will have retiree drug coverage -- down from [28 percent] in 1995.

  - ***Medigap***: Medigap, the standardized private insurance supplement for Medicare, offers prescription drugs in some of its plans. Its drug benefit has a $250 deductible, 50 percent coinsurance, and a cap on benefits spending of $1,250 or $3,000. Medigap premiums are expensive and virtually always underwritten, meaning that premiums are based on the person's health. The median premium for a plan with prescription drug coverage is about $1,100 more than a Medigap plan without drug coverage ($2,073 v $913 in 1998). Medigap premiums have been rising at double-digit inflation. At the same time, Medigap coverage has been declining. The actuaries project that only 6 percent of beneficiaries will have Medigap drug coverage in 2000, down from 10 percent in 1995.

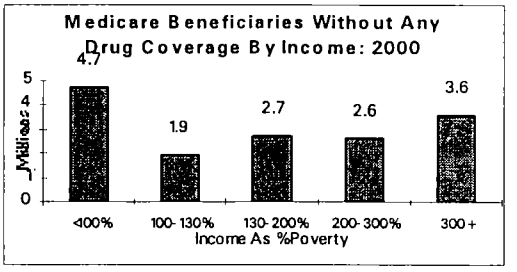
- **Public coverage exceeds private coverage:** More beneficiaries are projected to have public (30%) than private (23%) drug coverage -- suggesting that concerns about a new benefit "crowding out" private coverage are exaggerated.

  - ***Medicare managed care***: Over 90 percent of beneficiaries in Medicare HMOs have some type of drug coverage. Typical Medicare managed care plans have no deductibles and relatively low copayments, but limit the amount that they pay for benefits. In 1998, 42 percent of beneficiaries had coverage limited to $1,000 or less. Rising costs and lower Medicare payments could reduce benefits in the future.

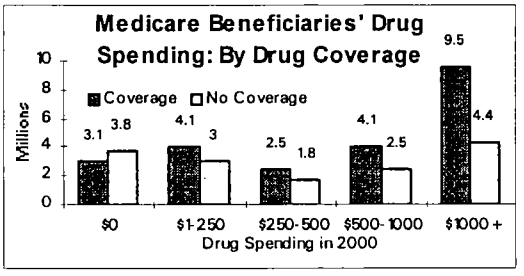
  - ***Medicaid***: Only about 4.3 million Medicare beneficiaries who are fully eligible for Medicaid (e.g., who receive Supplemental Security Income (SSI) or are medically needy) receive prescription drug coverage. This represents less than half of Medicare beneficiaries below poverty since Medicaid eligibility is typically only up to 75 percent of poverty. Moreover, even those beneficiaries who are eligible have low participation rates; only about 55 percent of beneficiaries eligible for SSI participate.

BENEFICIARIES WITHOUT DRUG COVERAGE: CHARACTERISTICS AND CONSEQUENCES

- **About 16 million beneficiaries (40%) are projected to have no drug coverage in 2000.** Lack of drug coverage is not just a problem for low-income beneficiaries; 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about $17,000 for a single, $23,000 for a couple in 2000). Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs. Older beneficiaries are less likely to have drug coverage, as are rural beneficiaries. Nearly half of rural beneficiaries have no insurance coverage for drugs.



- **Many beneficiaries with drug coverage have high drug spending.** According the Medicare actuaries' projections for 2000, beneficiaries with some type of insurance coverage (private or public) have higher spending and utilization than those with no insurance coverage for prescription drugs. Most research has found that lack of coverage reduced needed drug utilization. Despite this, nearly half of beneficiaries without any insurance coverage for prescription drugs have annual out-of-pocket spending of greater than $500.



- **Elderly without coverage pay higher prices.** Medicare beneficiaries without drug coverage pay higher prices than large HMOs, employers and the Veterans' Administration pay for the same drugs. Moreover, American senior citizens pay higher prices for drugs than citizens in other nations. For example, the average retail price for the top ten drugs for seniors are 72 percent higher in the U.S. versus Canada.

COMPARISON OF PRICES FOR DRUGS

Drug	Use	Price for Preferred Customers	Regular Price
Prilosec	Ulcers	$56.38	$111.94
Zocor	Cholesterol	$42.95	$104.80
Procardia	Heart	$67.35	$126.86
Zoloft	Depression	$123.88	$213.72

Source: Minority staff report to Committee on Gov't Reform

- **Larger financial burden**. Elderly with private insurance for drugs have about half the out-of-pocket financial burden for drugs than those without coverage. About 1 million beneficiaries without drug coverage have annual out-of-pocket expenses that exceed $3,000 – which more than 20 percent of income for at least half of these beneficiaries. Rural elderly have out-of-pocket costs that are 35 percent higher than urban elderly, and women have, on average, costs that are 20 percent higher than men, primarily because many are widowed and lower income.

Draft: RURAL BENEFICIARIES:
ISSUES WITH THE BREAUX-THOMAS MEDICARE PROPOSAL

Challenges Facing Rural Beneficiaries Today. About 9 million, or one in four, Medicare beneficiaries live in rural America.

- **Fewer doctors.** Only slightly more than 10 percent of physicians practice in rural areas, and some rural beneficiaries have to travel great distances for health care.

- **Fewer health plan options.** This year, 85 percent of all rural counties with three-fourths of rural beneficiaries have no Medicare+Choice plans available to them.

- **Greater health problems.** About 43 percent of rural beneficiaries 75 years old or older report fair to poor health, compared to 30 percent of beneficiaries in metropolitan areas.

- **Lower income**: Rural beneficiaries are more likely to be poor (13 percent versus 10 percent of urban elderly).

- **Less coverage for prescription drugs.** The proportion of rural Medicare beneficiaries with no insurance coverage for prescription drugs is about twice as high as that for urban residents. This is because rural beneficiaries have both less access to employer-based retiree coverage (since such coverage is typically associated with large firms) and Medicare managed care plans that typically offer drug coverage. As a result, the proportion of income spent on drugs is about 35 percent higher for rural than urban beneficiaries.

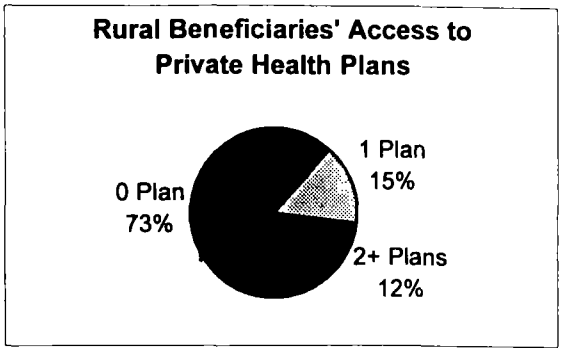
Effects of the Breaux-Thomas Proposal on Rural Beneficiaries. The Breaux-Thomas proposal would probably not help -- end could hurt -- rural beneficiaries.

- **Dilemma: Greater choice or higher premiums.** The Breaux-Thomas "premium support" proposal would limit the government contribution to all Medicare plans -- including the traditional Medicare fee-for-service program. Beneficiaries choosing low-cost plans would pay less and those choosing high-cost plans pay more. However, since the Medicare actuary estimates that traditional Medicare would be a high-cost plan, its premiums would be 18 to 30 percent more than current law (10 to 20 percent with increased efficiency).

  To help rural beneficiaries, the proposal would charge beneficiaries with no private plan options the current premium for traditional Medicare. However, this proposal puts beneficiaries in a difficult situation.

  - **Different premiums depending on location.** Within a state -- and even from town to town -- rural beneficiaries would pay different premiums for the same, traditional Medicare, depending on whether they have access to a private health plan option.

- **Millions of rural beneficiaries would not be protected against higher premiums.** Over 25 percent of rural beneficiaries have access to a Medicare managed care plan, and thus would pay higher premiums for traditional Medicare. Over half of those beneficiaries with access to private plans have only one option. Even if this single plan has limited capacity or does not include the beneficiary's physician or hospital, all beneficiaries in its area would either have to pay the higher premium for traditional Medicare or enroll in managed care.

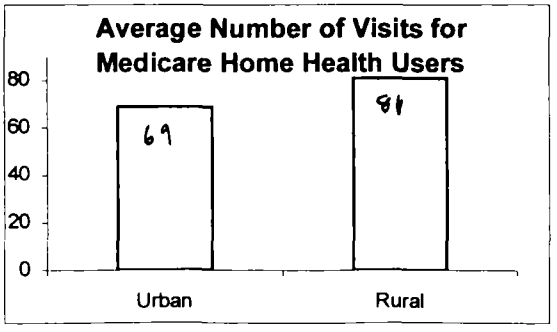


- **Premium protection ends if even one managed care plan enters a rural county.** The Breaux-Thomas plan would subsidize private plans that enter low-cost areas, increasing the likelihood that at least one plan option would be available. If one plan enters the area, the traditional Medicare premium would increase abruptly.

- **More likely to lose coverage as a result of raising Medicare's age eligibility.** Today, workers in rural America tend to have more physically demanding jobs and typically retire earlier: 36 percent of rural people ages 60 to 64 were retired, compared to 32 percent of urban people in the same age bracket. However, rural residents have less access to employer-based health insurance -- especially retiree health insurance. As such, rural beneficiaries are at greater risk of becoming uninsured if Medicare's age eligibility were raised.

- **Less able to purchase unsubsidized drug coverage**: The Breaux-Thomas plan would expand Medicaid coverage for beneficiaries with income up to 135 percent of poverty (about $11,000 for a single beneficiary, $15,000 for a couple). It would also provide access to -- but not premium assistance for -- Medigap and a new traditional Medicare drug option. However, since rural elderly disproportionately have lower income, it could be more difficult for them to afford premiums that could be as high as $1,000 annually.

- **More likely to have high home health care use -- and to suffer from an unlimited home health copay.** The Breaux-Thomas proposal would add an unlimited 10 percent home health copy. This is slightly higher than the $5 copay passed by the Senate in 1997, and does not contain a cap on beneficiary expenditures as was in that proposal. Rural beneficiaries are more slightly more likely than urban home health users to have more than 100 home health visits. The proportion of rural beneficiaries whose home health visits are greater than 100 is about 20 percent higher than that of urban beneficiaries. Combined with their lower average income and access to supplemental insurance coverage, this copay could pose a significant financial burden for



MEDICARE BENEFICIARIES IN RURAL AMERICA: ACCESS TO PRIVATE HEALTH PLANS, 1999

State	Access to Private Medicare Plans						
	No Plans	One Plan	Two Plans	Total	No Plans	One Plan	Two Plans
Alabama	232,657	20,142	-	**252,799**	92%	8%	0%
Alaska	17,326	-	-	**17,326**	100%	0%	0%
Arizona	-	54,969	39,020	**93,989**	0%	58%	42%
Arkansas	219,305	24,272	22,909	**266,486**	82%	9%	9%
California	86,566	73,704	13,955	**174,225**	50%	42%	8%
Colorado	67,794	18,668		**86,462**	78%	22%	0%
Connecticut	-	-	16,028	**16,028**	0%	0%	100%
Delaware	30,595	-		**30,595**	100%	0%	0%
District of Columbia	-	-	-	**-**	0%	0%	0%
Florida	133,232	47,812	43,600	**224,644**	59%	21%	19%
Georgia	345,562	-	18,269	**363,831**	95%	0%	5%
Hawaii	-	8,284	36,201	**44,485**	0%	19%	81%
Idaho	98,557	9,899	-	**108,456**	91%	9%	0%
Illinois	291,938	56,313	6,121	**354,372**	82%	16%	2%
Indiana	253,315	13,569	-	**266,884**	95%	5%	0%
Iowa	307,031	-	-	**307,031**	100%	0%	0%
Kansas	207,977	-	-	**207,977**	100%	0%	0%
Kentucky	354,152	-	-	**354,152**	100%	0%	0%
Louisiana	46,885	76,984	44,618	**168,487**	28%	46%	26%
Maine	80,920	19,716	-	**100,636**	80%	20%	0%
Maryland	-	60,561	-	**60,561**	0%	100%	0%
Massachusetts	-	3,508	11,698	**15,206**	0%	23%	77%
Michigan	285,731	17,719	-	**303,450**	94%	6%	0%
Minnesota	253,719	6,983	4,595	**265,297**	96%	3%	2%
Mississippi	297,190	-	-	**297,190**	100%	0%	0%
Missouri	317,151	12,155	-	**329,306**	96%	4%	0%
Montana	106,015	-	-	**106,015**	100%	0%	0%
Nebraska	153,338	-	-	**153,338**	100%	0%	0%
Nevada	26,196	-	-	**26,196**	100%	0%	0%
New Hampshire	45,781	11,356	-	**57,137**	80%	20%	0%
New Jersey	-	-	-	**-**	0%	0%	0%
New Mexico	80,925	19,848	7,217	**107,990**	75%	18%	7%
New York	121,033	65,309	56,795	**243,137**	50%	27%	23%
North Carolina	370,305	21,270	59,943	**451,518**	82%	5%	13%
North Dakota	70,730	-	-	**70,730**	100%	0%	0%
Ohio	90,589	147,134	96,599	**334,322**	27%	44%	29%
Oklahoma	94,075	51,786	98,371	**244,232**	39%	21%	40%
Oregon	74,010	53,097	49,256	**176,363**	42%	30%	28%
Pennsylvania	-	80,726	269,423	**350,149**	0%	23%	77%
Rhode Island	-	-	-	-	0%	0%	0%
South Carolina	191,551	-	-	**191,551**	100%	0%	0%
South Dakota	88,022	-	-	**88,022**	100%	0%	0%
Tennessee	183,512	104,243	30,100	**317,855**	58%	33%	9%
Texas	267,882	170,517	87,904	**526,303**	51%	32%	17%
Utah	57,030	-	-	**57,030**	100%	0%	0%
Vermont	66,710	-	-	**66,710**	100%	0%	0%
Virginia	297,732	99,684	52,726	**450,142**	66%	22%	12%
Washington	59,214	37,012	69,339	**165,565**	36%	22%	42%
West Virginia	156,429	48,607	-	**205,036**	76%	24%	0%
Wisconsin	287,242	-	12,536	**299,778**	96%	0%	4%
Wyoming	45,082	-	-	**45,082**	100%	0%	0%
Puerto Rico	84,066	-	-	**84,066**	100%	0%	0%
TOTAL	**6,861,006**	**1,435,847**	**1,147,223**	**9,444,076**	**73%**	**15%**	**12%**

DATE: 4/21

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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[ ] ANDREA LEVARIO

[ ] ROGER MCCLUNG

[ ] TANISHA PARKER

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[ ] MARC SMOLONSKY

[ ] STEPHANIE WILSON

[ ]

(INCLUDING COVER): _____

REMARKS:

ASAP make edits fax to Bob Reich fax directly to Chris Thank

Testimony of

Donna E. Shalala

U.S. Secretary of Health and Human Services

Before the

Senate Budget Committee

copy for Rich Me Bob

April 22, 1999

Chairman Domenici, Senator Lautenberg, distinguished members of the Committee, I appreciate having the opportunity to appear before you today to discuss the future of Medicare. As you know, the Medicare Trustees projected last month that the life of the Medicare Trust Fund has been extended until 2015 – 7 years longer than projected in last year's report. This report affirms that the steps we have taken together in the past are paying real dividends. But it also underscores the need for additional action to strengthen and modernize the program for the future.

As we near the end of the 20th Century, we can all point with great pride to the legacy of the Medicare program. Since its enactment in 1965, Medicare has helped to lift and keep a generation of Americans out of poverty while improving and extending the quality of their lives. During this time, the average life expectancy of our senior citizens has increased by three years, from 79 to 82 years. Poverty among the elderly has dropped by nearly two-thirds. And access to care has increased by one-third.

Before Medicare was enacted, more than half of our senior citizens were uninsured at a time in their lives when their need for health care was the greatest. Today, virtually every American over the age of 65, and millions of other Americans who have disabilities, live with the security of knowing that Medicare is there for them if and when they need it. This peace of mind also is vitally important to millions and millions of working men and women in this country who worry about the well-being of their parents and their grandparents.

President Clinton has a passionate commitment to strengthen Medicare for the future. When he took office six years ago, Medicare was actually projected to go bankrupt by this year. Working with the Congress, he has supported administrative and legislative changes that, along with a strong economy, have resulted in projected trust fund solvency through 2015. The Administration is gratified by the Medicare Trustees' recent projection. The Congress should be too.

But as the President said last month, we should not be lulled into thinking that nothing more needs to be done. Over the next 35 years, the size of the Medicare population will double from 39 million to 80 million beneficiaries. While the emergence of new technologies will improve the quality of care, they may also be costly. The Trustees' Report points out that "substantially greater changes in income and/or outlays are needed, in large part as a result of the impending retirement of the baby boom generation."

The President will submit a plan soon that builds on the work of the Bipartisan Commission on the Future of Medicare and includes real changes to modernize the program and provide a long overdue prescription drug benefit. And it also will offer a historic opportunity to begin to address the central challenge facing Medicare – a tremendous influx of new beneficiaries – through our proposal to devote 15 percent of the budget surplus to extend the solvency of the trust fund for another decade.

Mr. Chairman, before I discuss our plans for the future, ~~in detail~~, allow me to report on where we are today. In our latest report, the Trustees projected that the Medicare HI trust fund spent an estimated $135.8 billion in 1998 and received $140.5 billion in income from payroll taxes and interest income. This is the first time since 1994 that income to the trust fund exceeded expenses. At the end of 1998, the trust fund's total assets had increased from $115.6 billion to $120.4 billion.

At the same time, the Supplemental Medical Insurance Trust Fund spent $77.6 billion in 1998, while it received $87.7 billion in income for a net increase of $10.1 billion in assets. Total assets in the SMI trust fund at the end of 1998 were $46.2 billion.

These figures represent a substantial improvement from 1997 and based on current projections, they indicate that the Hospital Insurance Trust Fund should remain solvent until 2015. Taking the last two annual reports together, we have extended the life of the HI trust fund by a full 14 years and cut the 75 year actuarial deficit by 66 percent.

The reasons for this improvement are perhaps more important than the numbers. The Trustees and the Medicare actuaries found several factors contributed to the economic good news for Medicare.

First, the robust national economy with its combination of low unemployment and low inflation has helped to increase payroll tax revenue into the trust fund and hold the line on health care costs.

Second, the Department's rigorous management of the Medicare trust fund and our historic attack on waste, fraud and abuse in the Medicare program have yielded some remarkable results. Over the last two years alone, our efforts to halt these practices have returned more than $1.2 billion to the Medicare Trust Fund. This is the first time in the history of the program than an Administration's efforts to end waste, fraud and abuse have been identified as having a positive impact on the life of the trust fund. I'd like to single out the Health Care Financing Administration (HCFA) for special praise in this area, along with the HHS Office of the Inspector General and the Department of Justice.

Third, but by no means last, the bipartisan Balanced Budget Act, which is an important legacy of this Committee, and the Chairman and Ranking Member in particular. The BBA made some very important and overdue changes in the way Medicare pays doctors, hospitals, nursing homes, home health agencies, and other health care providers. As members of this Committee know, Medicare is the single largest purchaser of health care services in the United States. The way in which we pay for care often influences the entire health care system. The BBA also mandated the development of new payment systems for home health care, skilled nursing facility care, rehabilitation services, and outpatient hospital services. These new systems, while

challenging to develop, will help to make Medicare a more prudent purchaser of health care services.

While we modernized our payment systems, we also modernized the Medicare benefit package to include important new prevention services, including annual screening mammograms, for women over 40, prostate cancer screening, colorectal cancer screening and diabetes management. These changes made Medicare more like the benefit packages offered to working-age Americans. In the long run, these new benefits also will help to reduce Medicare spending growth by keeping beneficiaries healthier.

While the BBA played a vital role in strengthening HI solvency, it also created a major challenge for the HCFA and all of HHS. When I asked Nancy Ann Min DeParle to take the HCFA helm just after the BBA was enacted, I told her it was one of the most difficult jobs in Washington. Thanks to the BBA, that was an understatement. Working under extraordinary conditions, the men and women of HCFA have done a remarkable job of managing the implementation of this important law.

BBA implementation has been one of HHS' top priorities for the past two years. The BBA included 335 provisions affecting HCFA programs and HCFA has already fully implemented more than half of them. Many more provisions are partially implemented and are on track for full implementation according to the timetable laid out by the Act. In the last year,

HCFA has published 92 regulations and Federal Register notices, including those to expand Medicare's benefit package for diabetes management, bone density measurement, colon cancer screening, pap smears, pelvic exams, mammograms, and clinical breast exams. I am especially proud of our work in this area.

In the area of payment system reforms, HCFA has issued regulations modifying inpatient hospital payment rules, established a prospective payment system for skilled nursing facilities, refined the physician payment system, and begun work on prospective payment systems for home health care, outpatient hospital services, and rehabilitation hospitals.

We have also begun to implement a very important test of market forces to help control Medicare costs for durable medical equipment.

I should remind the Committee that the agency accomplished this Herculean task at the same time it tackled some of the most difficult Year 2000 computer challenges in the federal government.

The BBA also expanded the options available to beneficiaries who choose to obtain benefits through a private health plan. New options include preferred provider organizations or PPOs, provider-sponsored organizations or PSOs, medical savings accounts or MSAs, and private fee-for-service plans. HCFA has issued regulations establishing the new Medicare-Plus-

Choice program and is working with health plans and others to help them offer their products to Medicare beneficiaries.

HCFA also has recently taken several steps to address some of the concerns raised by plans and others with the initial BBA regulations. Final rules issued in February will make Medicare-Plus-Choice more flexible for plans and beneficiaries. And just this month, HCFA announced plans to move the deadline for plans' submission of their adjusted community rate applications to July 1. This will help plans by giving them more time to establish their rates. The President's FY2000 budget also announced several proposals intended to protect beneficiaries whose Medicare-Plus-Choice plans may have terminated or may have reduced their service areas. These proposals would permit certain beneficiaries the opportunity to enroll in Medigap and also would expand the Medigap options to which these specified enrollees may have access.

Mr. Chairman, we are very committed to successful implementation of Medicare-Plus-Choice. Since the Clinton Administration took office, enrollment in managed care has tripled to 6.8 million seniors. An important element of this program is beneficiary education. HCFA has launched a multi-pronged national education campaign designed to assure that beneficiaries make choices based on good, solid, unbiased information. We have developed a new Medicare handbook entitled "Medicare and You," that was tested last year in five states. We now have a national toll-free call center to answer questions and provide additional information. We have

designed a consumer-friendly Internet site *www.medicare.gov* that includes comparative information about health plans being offered in each community. We have enhanced beneficiary outreach and counseling at the State Health Information Assistance Programs. And we participated in more than 1,000 state and local outreach events around the country in senior centers, town halls, and radio call-in shows.

Our decision to test these materials and processes in a small number of states last year has proven to be a very wise move. Despite the complications created by health plan decisions to withdraw from some Medicare markets, these tests have given us valuable information that will make our 1999 efforts even more successful.

Mr. Chairman, we know that members of Congress are hearing from a variety of providers in their states and districts about the effects of some of the payment reforms included in BBA. Ms. DeParle and I have received literally thousands of letters, and have discussed these issues at great length with members of Congress, providers and their trade association representatives. Through administrative actions, we will continue to address these concerns where appropriate and to make sure that beneficiaries continue to have access to the care they need. ~~Let me assure you that we will not compromise our beneficiaries, and we will make sure that beneficiaries continue to have access to the care they need~~. At the same time, we must recognize that changes in the BBA would require offsetting cuts elsewhere or new revenues. These changes also could adversely affect the progress we have made together in extending the

life of the Trust Fund. As we continue to monitor the effects of BBA, we look forward to working in a bipartisan fashion to ensure that Medicare beneficiaries continue to receive quality health care services.

Now, I would like to turn to the future and discuss both the work of the Bipartisan Commission on the Future of Medicare and the President's plan to strengthen and modernize the program.

First, let me say that we appreciate the hard work of Senator Breaux and Congressman Thomas, as well as the thoughtful contributions of the other Commission members. In particular, I want to recognize Senators Gramm and Frist, whom I consult with often on a broad range of health care issues. While there was not a sufficient number of votes to report out a set of recommendations, the Commission's work helped to highlight the challenges that we face as we move forward to address Medicare's future. The Breaux-Thomas proposal has advanced the debate about Medicare in important ways and recommends a number of ideas worthy of consideration.

The proposal calls for making the traditional Medicare program more competitive by adopting many of the competitive management tools that are used in the private sector. Per capita spending growth in Medicare has closely tracked growth in the private sector over the years. All of us should be interested in making sure that the traditional program has the tools

widely used by the private sector and Medicare managed care (or Medicare-Plus-Choice) plans to ensure continued restraint in spending growth, while recognizing that growth in health care spending has historically exceeded growth in GDP.

The Breaux-Thomas proposal also would rationalize Medicare's complicated, confusing cost sharing and proposes doing so in important ways like eliminating cost sharing for preventive services.

The proposal also recognizes the need for expanded coverage of prescription drugs. Using the Medicaid program, it contains a modest but positive step toward providing drug coverage to low income Medicare beneficiaries.

However, the Breaux-Thomas proposal falls short in a number of key areas and therefore, we cannot support it. First and foremost, the proposal does not address Medicare's long term solvency and ignores the need for new revenues to finance care for the growing numbers of new beneficiaries. Commission staff estimated that the plan would produce net Medicare savings of only $102 billion over 10 years, less than one third of the savings assumed under the BBA. And significant savings would come from shifting the cost of Medicare Direct Medical Education to other areas of the budget. The lack of financing in the Breaux-Thomas proposal would make Medicare's financial problems much harder to solve in the future.

Second, the plan derives a substantial portion of its savings from increasing costs for Medicare beneficiaries. ~~We do not believe this is the most appropriate way to strengthen and protect the program~~. For example, the proposals to raise the eligibility age from 65 to 67 and to impose unlimited per visit home health copays comprise over 20% of the savings in the Breaux-Thomas plan. The proposal to raise the eligibility age includes no workable policy to prevent an increase in the number of uninsured Americans among this vulnerable population.

Under the name of "competition," the centerpiece of the Breaux-Thomas proposal – premium support – also derives a substantial portion of its savings from shifting costs to beneficiaries in the form of higher premiums for traditional Medicare relative to current law. The independent Medicare actuary estimated that under the Breaux-Thomas proposal that was presented in February, traditional program (fee for service) premiums would rise by 18 to 30 percent, or 10 to 20 percent if Congress enacted the traditional program reforms. As a result of this premium support design, states also would face a significant increase in costs since Medicaid pays Medicare premiums for some low income beneficiaries.

We are also concerned about the potential effect of this proposal on rural areas. The Breaux-Thomas plan would protect against fee for service premium hikes for beneficiaries who live in an area with no Medicare managed care offering. But if one private plan comes to their area -- and that plan does not include their physician -- they would have to pay a much higher premium to stay in the traditional program and keep their physician. This approach would lead

to an unprecedented situation in which Medicare beneficiaries in different counties could pay substantially different amounts for the same fee for service benefit package.

The Breaux-Thomas plan includes a modest prescription drug benefit; however, because it is administered as a means tested Medicaid benefit, nearly 60 percent of Medicare beneficiaries without drug coverage would not qualify. And experience with Medicare premium assistance programs shows that only about half of people eligible for these Medicaid benefits actually enroll.

A final concern with the Breaux-Thomas plan is its call for creation of a new bureaucracy to oversee the premium support program. This board would approve health plan benefit packages and rates, decide on service areas, and enforce financial and quality standards among other activities. Not only is this new bureaucracy unneeded, but it could remove billions of dollars from traditional government oversight and accountability since it is not subject to executive branch rules. This could be particularly problematic in our fight against waste, fraud and abuse.

In light of his concerns with the Breaux-Thomas proposal, the President has pledged to come forward with his own recommendations to strengthen and modernize the Medicare program. We are committed to working with the Congress to develop and pass a plan this year to strengthen Medicare for the next century. We are working to develop a plan that conforms to

the

principles he outlined in January:

* Make the program more efficient and competitive;

* Maintain and improve Medicare's guaranteed benefits, including a prescription drug benefit, and;

*Assure adequate financing by dedicating 15% of the surplus to Medicare.

To make the traditional program more efficient, we believe that Medicare should be allowed to use the same effective practices that private health insurers use to constrain costs, including selective contracting with lower cost, higher quality providers, and competitive bidding for services like medical supplies. We are examining other options to reduce fraud, constrain costs, and make payments more competitive and efficient.

Our proposal also will ensure that Medicare's guarantee of benefits is strong. Medicare provides coverage for some of our most vulnerable citizens. We must strengthen the program but not do so at the expense of a clear, defined set of benefits.

One of the President's top priorities is to provide a long overdue prescription drug benefit. Nearly all beneficiaries use prescription drugs and the cost they pay for those drugs is

three times as high as that paid by of other adults. Yet less than 25 percent of beneficiaries have private retiree or Medigap coverage and these numbers are declining. Beneficiaries without drug coverage typically pay much higher prices than insurers do – exacerbating the problem.

Finally, the President's proposal will put Medicare on sounder financial footing by dedicating 15% of the budget surplus to the program for the next 15 years. This ~~amounts to an~~ infusion ~~of $686 billion~~ of much needed revenues ~~to~~ would extend the HI trust fund for another decade. The plan does not create an unlimited tap on general revenues, but instead invests a fixed portion of the surplus in Medicare to cover the temporary but overwhelming influx of retirees. The surplus was largely created by the baby boom generation and makes sense as a one-time funding source for Medicare.

Mr. Chairman, members of the Committee, by working together we have made remarkable progress in keeping our promise of high-quality, affordable health care for the 39 million beneficiaries of the Medicare program today. And we have made important progress toward assuring such access to future beneficiaries. But we still face a difficult challenge. Despite our progress, the Medicare program must be strengthened, modernized, and put on a strong financial footing to address the needs of future generations of senior citizens. The President and his Administration are committed to working with the Congress to achieve that result.

Mr. Chairman, 34 years ago, our nation made a promise to some of our most vulnerable citizens. We promised that if they worked hard and saved for their retirement, we would make sure that they have access to the high-quality, affordable care they need to live their later years in security. Our parents and grandparents kept their end of the bargain. Now it is time for us to do the same. I look forward to working with the Members of this Committee and both houses of Congress to make sure that we keep our word.

I'd be happy to answer any questions. Thank you.

from the office of

Senator Edward M. Kennedy

of Massachusetts

STATEMENT OF SENATOR EDWARD M. KENNEDY
INTRODUCTION OF LEGISLATION TO PROVIDE PRESCRIPTION DRUG COVERAGE
UNDER MEDICARE FOR SENIOR CITIZENS

For Immediate Release
April 20, 1999

Contact: Jim Manley
(202) 224-2633

Today, we are introducing legislation to add a long overdue benefit to Medicare -- coverage of prescription drugs. Medicare is a promise to senior citizens. It says "Work hard, contribute to Medicare during your working years, and you will be guaranteed health security in your retirement years." But too often that promise is broken, because of Medicare's failure to protect the elderly against the high cost of prescription drugs.

Our legislation will provide every senior citizen with Medicare coverage for up to $1,700 worth of prescription drugs a year, and additional coverage for those with very high drug costs. Medicare will contract with the private sector to implement the coverage. The bill will also require private Medigap plans to include coverage beyond that amount.

The average senior citizen fills eighteen prescriptions a year, and takes four to six prescription drugs daily. Many of them face monthly bills of $100, $200, or even more to fill their prescriptions. Too often, the lack of prescription drug coverage condemns senior citizens to second-class medicine. Often, they decide to go without the medication essential for good health, because they have to pay other bills for food or heat or rent. These impossible choices will only worsen in the years ahead, since so many of the miracle treatments and cures of the future will be based on pharmaceutical products.

This legislation is a lifeline for every senior citizen who needs prescription drugs to treat an illness or maintain their health. It assures that today's and tomorrow's senior citizens will be able to share in the medical miracles that we can expect in the new century of the life sciences. It addresses the greatest single gap and the greatest anachronism in Medicare today.

When Medicare was first enacted in 1965, its coverage was patterned after typical private insurance policies of the time -- when few such policies covered prescription drugs. Today, prescription drug coverage is virtually universal in private plans, but Medicare is still caught in its 1965 time warp.

-more-

SENATOR KENNEDY ON MEDICARE PRESCRIPTION DRUG COVERAGE 2-2-2

This legislation has been carefully developed to respond to the legitimate concerns of the pharmaceutical and biotechnology industry. We have consulted with many leading firms on the development of this plan, and we believe that the industry will work with us to refine it and enact it. The most profitable industry in America has a strong interest in assuring that the miracle products it creates are affordable for senior citizens.

Prescription drug coverage under Medicare will not come cheaply. Possible sources of financing include earmarking part of the surplus, increased revenues from tobacco, and savings obtained by reducing the improper use of prescription drugs, which now cost Medicare more than $20 billion a year in avoidable hospital and physician costs.

There are many possible ways of financing this benefit. A consensus on the best possible financing sources will develop as the Congress considers this issue. But we believe there is a strong bipartisan consensus right now on the need to provide the coverage, because it is literally a matter of life and death for senior citizens in communities throughout America. It is time for Congress to listen to their voices.

-30-

ACCESS TO Rx MEDICATIONS IN MEDICARE ACT OF 1999

Benefit

--New benefit under Part B

--20% coinsurance; special $200 deductible. Special assistance for low-income beneficiaries (i.e., income <135% of poverty).

--Basic coverage of first $1,700 worth of expenditures annually, including cost-sharing.

--Stop-loss coverage once annual out-of-pocket spending reaches $3,000.

Administration of benefit

--All benefits provided through private sector:

- Secretary enters into contracts with at least two private entities (pharmacy benefit management organizations, insurance companies, consortiums of retail pharmacists, etc.) in each region to provide benefits. Beneficiaries choose which one to sign up with.
- Medicare HMOs provide benefit directly. Medicare+Choice payments adjusted to reflect additional cost of drug coverage.
- Private businesses offering coverage equal to or greater than Medicare benefit as part of retiree health program are eligible for payments to maintain coverage.
- Beneficiaries who have and maintain equivalent private sector coverage may opt-out of program entirely.

--All programs must provide convenient access to drugs through retail pharmacies.

--Programs must include measures to assure proper use of prescription drugs and reduce adverse drug reactions or other drug-related problems.

--Programs must allow patients to receive most appropriate drug.

--Standard Medigap packages are redesigned by the Secretary of HHS and NAIC to reflect new Medicare benefit, and provide complimentary coverage, where appropriate.

Cost of program and financing

--Cost estimates not yet available. Beneficiaries pay 25% of cost through Part B premium (with assistance for low-income). Additional financing possibilities include: higher tobacco taxes, recoupment of federal costs for tobacco-related diseases, unallocated portion of surplus, savings from long-term Medicare reform proposal (in reconciliation or alone), and savings from reduced hospitalizations and other costs related to inappropriate use of prescription drugs.

Access to Rx Medications in Medicare Act of 1999
Summary

THE NEED

When Medicare was enacted in 1965, outpatient prescription drug coverage was not a standard feature of private health insurance policies. Now, virtually all employment-based policies provide prescription drug coverage, but Medicare does not.

More than one-third of Medicare beneficiaries have no coverage for outpatient prescription drugs. While other elderly and disabled beneficiaries have some level of outpatient prescription drug coverage through Medicare+Choice plans, individually purchased Medigap or retiree health coverage, too often that coverage is inadequate, expensive or unreliable.

LEGISLATIVE PROPOSAL

This legislation would create a new outpatient prescription drug benefit under Part B. The benefit has two parts -- a basic benefit that will fully cover the drug needs of most beneficiaries and a stop-loss benefit that will provide much needed additional coverage to the beneficiaries who have the highest drug costs.

The proposal administers and delivers the benefit through private entities and private sector performance benchmarks -- rather than HCFA or federally designated price controls. All beneficiaries would be covered by the new benefit. Beneficiaries enrolled in Medicare+Choice plans would receive the benefit through their plan. Beneficiaries in conventional Medicare would enroll with an approved program in their area of residence, following the general model of Medicare+Choice enrollment.

In addition, the proposal would preserve and improve existing coverage in the private market that is equal to or greater than the new coverage under Medicare. Beneficiaries with equivalent coverage through a retiree health plan would be able to keep that coverage and HHS would provide payment to the plan equal to the payment that would otherwise be paid on behalf of the beneficiary to one of the new private entities.

The benefit

Outpatient drugs covered under this Act are FDA-approved therapies that are dispensed only by prescription, including insulin and biologics, and that are reasonable and necessary to prevent or slow the deterioration of, and improve or maintain the health of covered individuals. This Act would *not* cover over-the-counter products or therapies that are currently covered under Medicare (e.g., those that are administered "incident to" physician services).

After beneficiaries meet a separate drug deductible of $200, coverage is generally provided at levels similar to regular Part B benefits -- with the beneficiary paying not more than 20 percent

of the program's established price for a particular product. The basic benefit would provide coverage up to $1,700 annually. Medicare would provide "stop-loss" coverage (i.e., Medicare would pay 100 percent) once annual out-of-pocket expenditures exceed $3,000. Beneficiaries with drug costs in excess of the basic benefit -- but below the stop-loss trigger -- would be allowed to self-pay for additional medications at the private entity's discounted price.

This benefit package provides a new and much needed guarantee of coverage for all beneficiaries, and will fully cover the prescription drug needs of approximately 80 percent of beneficiaries.

Use of private sector and support of existing coverage

Coverage would be provided through private entities under contract with HHS. Eligible entities include pharmaceutical benefit management companies, insurers, networks of wholesale and retail pharmacies, and other appropriate organizations. Eligible entities would submit competitive bids to the Secretary for regional coverage -- regions would be determined by the Secretary and structured in such a way as to encourage participation by and competition among private entities. Service areas would consist of at least one state whenever possible.

Bids would be awarded based on shared risk, capitation or performance to entities that meet the requirements of the Act and provide for discounts comparable to those garnered by other large private sector purchasers. There is no fee schedule or rebate structure. The Secretary shall award at least two bids in an area, if such bids meet the requirements of the Act, encourage competition and improve service for beneficiaries.

Entities may employ a variety of cost-containment techniques used in the private sector (e.g., formularies, differential cost-sharing for certain products, etc.), subject to guidelines and beneficiary protections established in the Act. Entities must contract with a sufficient number and distribution of retail pharmacies throughout the plan's service area to assure convenient access for covered beneficiaries.

Additional assistance for low-income beneficiaries

Beneficiaries with incomes between the level for Medicaid eligibility and 135 percent of poverty would receive comprehensive wrap-around coverage through Medicaid, including assistance with cost-sharing and premiums.

Incentive to maintain current private market coverage

To maintain coverage in the retiree health market, employers who offer retiree drug coverage that is equal to or better than the new Medicare benefit would be eligible for a payment equal to the payment that would otherwise be made to the local private entity. This would help beneficiaries with comprehensive drug coverage in retiree health plans to keep their current coverage.

Measures to decrease drug-related problems

Improper use of or lack of access to prescription drugs is estimated to cost Medicare more than $20 billion annually (primarily through avoidable hospitalizations and admissions to skilled nursing facilities). Participating private entities must use systems to assure appropriate prescribing, dispensing and use of covered therapies. These programs must include on-line prospective review and methods to identify and educate pharmacists, providers and beneficiaries on (1) instances or patterns of unnecessary or inappropriate prescribing or dispensing or substandard care, (2) potential adverse reactions, (3) inappropriate use of antibiotics, (4) appropriate use of generic products, and (5) patient compliance.

Medigap reforms

The Secretary and the National Association of Insurance Commissioners would be required to revise the standard Medigap packages to reflect the new Medicare benefit, and provide for coverage that compliments, but does not duplicate, such coverage in an appropriate number of standard packages.

ESTIMATED COST AND FINANCING

The Congressional Budget Office has not yet estimated the costs or potential savings associated with this proposal. The proposal does not specify the financing mechanism, but viable options include (1) recovering -- through legislation or litigation -- the Medicare costs attributable to treating tobacco-related diseases and conditions, (2) an increase in the federal tobacco tax, (3) a small portion of the unallocated surplus, or (4) savings achieved as part of the financing of more comprehensive Medicare reform legislation.

April 20, 1999

Access to Rx Medications in Medicare Act of 1999
Fact Sheet

The greatest gap in Medicare coverage is the lack of a prescription drug benefit. The time has come to modernize Medicare's benefits by including coverage for outpatient prescription drugs.

Coverage

- When Medicare was enacted in 1965, outpatient prescription drug coverage was not a standard feature of private insurance policies. Today, however, virtually all employment-based policies provide prescription drug coverage.[1]

- Approximately one-third of Medicare beneficiaries have no prescription drug coverage. Coverage among the remaining beneficiaries is often inadequate, unaffordable and uncertain. Approximately 12 percent receive limited coverage through individually purchased Medigap policies, which are extremely expensive and often difficult to obtain. About six percent of Medicare beneficiaries have limited drug coverage through Medicare HMOs, but many plans are cutting back or eliminating drug coverage. Only about one-third of beneficiaries have reasonably comprehensive coverage, through an employment-based retirement plan or through Medicaid -- and the proportion with employment-based coverage is declining.[2]

Spending and utilization

- Purchase of prescription drugs accounts for the largest single source of out-of-pocket health costs for Medicare beneficiaries.[3]

- About 85 percent of the elderly use at least one prescription medicine during the year. The average senior citizen takes more than four prescription drugs daily and fills an average of eighteen prescriptions a year. It is not uncommon for seniors to face prescription drug bills of at least $100 a month.[4]

- The elderly, who make up 12 percent of the population, are estimated to use one-third of all prescription drugs.[5]

- Lack of Medicare coverage disproportionately increases the financial burden on women, rural residents, low-income beneficiaries and older beneficiaries.[6]

- A 1993 study, before the most recent surge in drug costs, reported that one in eight senior citizens said they were forced to choose between buying food and buying medicine.[7]

- Medicare beneficiaries without supplemental private coverage for prescription drugs

spend twice as much on prescription drugs as their counterparts with private insurance.[8]

- Increasingly, the miracle cures of the future will depend on pharmaceuticals developed through new breakthroughs in biology and biotechnology. These cures will generally save money overall, but the individual products will be expensive. The dollar volume of drug sales last year increased 16.6%, but most of the increase was due to greater use of costly new drugs, rather than price increases.[9]

- Medicare beneficiaries pay exorbitant prices for the drugs they buy, because they generally do not have access to discount programs available to other buyers. A study of five commonly prescribed drugs found that Medicare beneficiaries paid twice as much as the drug companies' favored customers.[10]

- Elderly persons without drug coverage are among the last purchasers who pay full price. According to a recent Standard and Poor's report on the pharmaceutical industry, "[d]rugmakers have historically raised prices to private customers to compensate for the discounts they grant to managed care consumers." Because Medicare beneficiaries are among the only private patients without additional coverage, they shoulder most of the burden generated by the industry's preference for cost-shifting.[11]

Adequate coverage and improved utilization are wise investments

- Assuring Medicare beneficiaries access to drugs in a well-managed program can produce immense savings for the Medicare program. Savings arise because seniors are able to afford to take the drugs that have been prescribed for their condition and because it is easier to encourage compliance with drug regimens and avoid complications or interactions because of inappropriate use. Improper use of prescription drugs costs Medicare more than $20 billion annually, primarily through avoidable hospitalizations and admissions to skilled nursing facilities.[12]

- One study found that hospitals costs for a preventable adverse drug event run nearly $5,000 per episode.[13]

- GAO reported in June 1996 that Medicaid's automated drug utilization review system reduced adverse drug events and saved more than $30 million a year in just five states.

Research and development

- The pharmaceutical industry spent more than $21 billion in research and development in 1998.[14] Ensuring access for the elderly through this proposal will provide a natural market for new and innovative therapies, thereby promoting additional investments in research and development.

Endnotes

1. Department of Labor, *Employee Benefits in Small Private Establishments.*

2. The Lewin Group, "Current Knowledge of Third Party Outpatient Drug Coverage for Medicare Beneficiaries," November 9, 1998, cited in staff documents, Medicare Commission; Margaret Davis, et al., "Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries," *Health Affairs*, January-February, 1999.

3. AARP, "Out-of-Pocket Spending."

4. Stephen H. Long, "Prescription Drugs and the Elderly: Issues and Options," *Health Affairs*, Spring 1994.

5. AARP Public Policy Institute, "Overview: Lack of Coverage Burdens Many Medicare Beneficiaries," September 1998.

6. Jeanette Rogowski, PhD, et al, "The Financial Burden of Prescription Drug Use Among Elderly Persons," *The Gerontologist* 37:4 (August 1997).

7. *American Pharmacy*, October, 1992; HCFA Office of Strategic Planning, Data from the Current Beneficiary Survey, cited in staff documents, Medicare Commission; Department of Health and Human Services, unpublished data; Committee on Government Reform and Oversight, U.S. House of Representatives, Minority Staff Report, "Prescription Drug Pricing in the United States: Drug Companies Profit at the Expense of Older Americans," October 20, 1998.

8. Rogowski, *The Gerontologist* 37:4 (August 1997).

9. Elyse Tanoye, Wall Street Journal, November 16, 1998.

10. Committee on Government Reform and Oversight, "Prescription Drug Pricing."

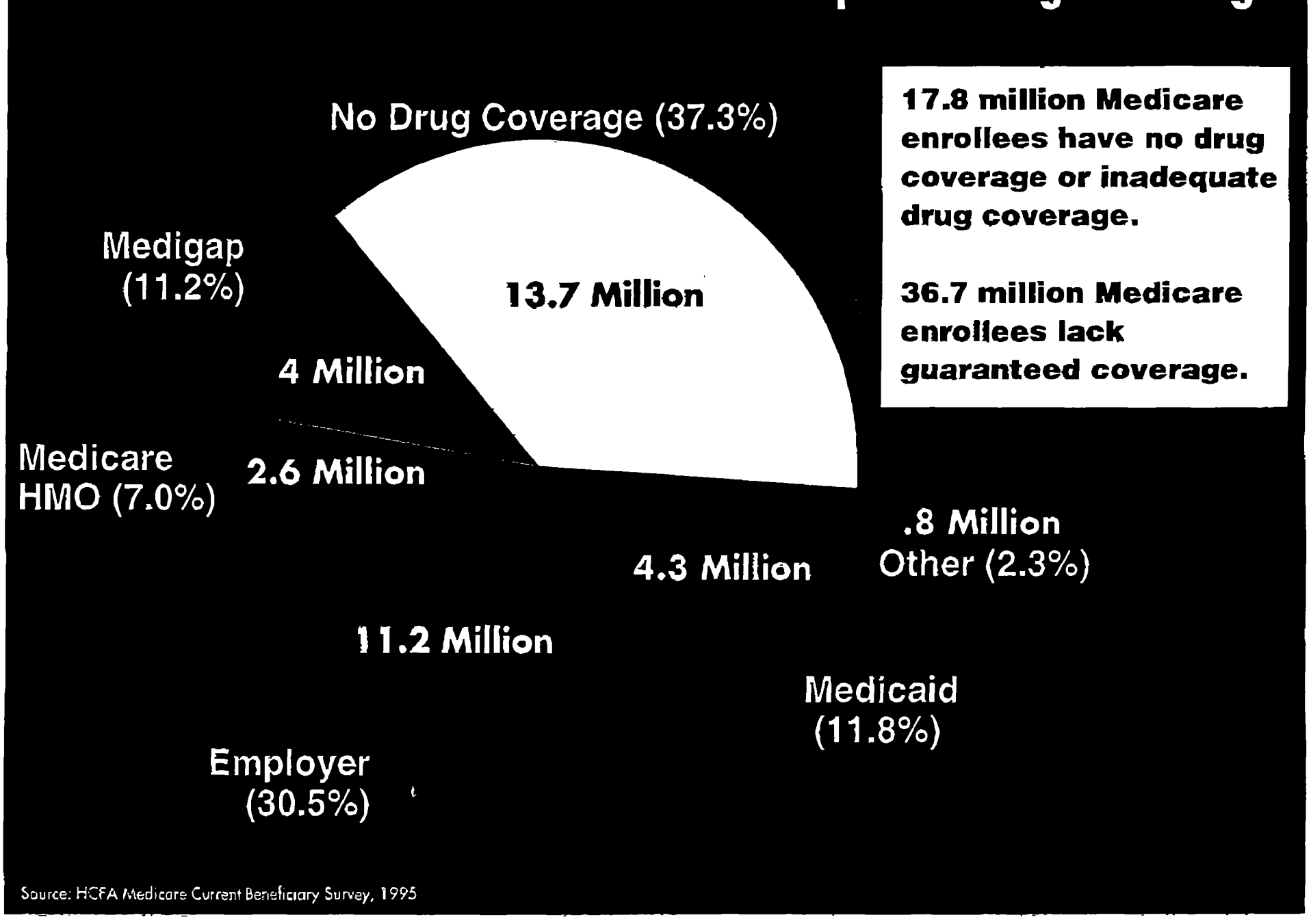
11. Ibid.

12. Prescription Drugs and the Elderly: Many Still Receive Potentially Harmful Drugs Despite Recent Improvements (GAO/HEHS-95-152, July 24, 1995); 60 FR 44182 (August 24, 1995).

13. David W. Bates, Md, MSc, et al, "The Costs of Adverse Drug Events in Hospitalized Patients," *JAMA,* January 22/29, 1997.

14. Pharmaceutical Research and Manufacturers of America, "The Value of Pharmaceuticals," 1998.

Senior Citizens Need Medicare Prescription Drug Coverage



37 Million Reasons Why There Should Be A Medicare Prescription Drug Benefit

- The elderly represent only 12% of the population, but use approximately 1/3 of all prescription drugs.
- The average senior citizen takes more than 4 prescription drugs daily and fills an average of 18 prescriptions a year.
- Many senior citizens have prescription drug costs in excess of $100 a month.
- 1 in 8 senior citizens reported choosing between buying food and medicine in 1993.

INITIAL MEDICARE OUTREACH

SENATE

Daschle Medicare Policy Group TBD

Finance Committee Democrats (First meet with staff, then subsequent meetings with Senators)
- Moynihan
- Baucus
- Rockefeller
- Conrad
- Graham
- Bryan
- Robb

Other Early Outreach (Meet with staff individually then decide whether meeting with Senator(s) necessary)
- Lieberman
- Kennedy
- Wyden
- Bayh
- Feinstein
- Landrieu
- Lincoln
- Dorgan
- Durbin
- Torricelli
- Edwards
- Lautenberg
- Murray
- Mikulski

Senate Republicans (Staff)
- Chafee
- Grassley
- Hatch
- Jeffords
- Snowe
- Collins

HOUSE

Leadership Group (Gephardt, Ranking Members, etc.)
Medicare Task Force (Members)
Commerce Committee Democrats (Members)

Caucuses/Groups
Congressional Black Caucus
(Offer member briefing but assume staff briefing)
Congressional Hispanic Caucus
(Offer member briefing but assume staff briefing)
Blue Dogs (Members)
New Democrats (Members)

Republicans (Meet with staff individually then decide on Members as appropriate)
- Johnson (CT)
- Houghton
- Bilirakis
- Upton
- Greenwood
- Ganske
- Lazio

On Hold
Ways & Means Democrats (On hold per Committee staff)

Individual Members (On hold per Gephardt's preference for group consultations)
- Dingell
- Rangel
- Stark
- Cardin
- McDermott
- Kleczka
- Tanner
- Thurman
- Waxman
- Brown
- Spratt

Note to Larry Stein

Please review the attached list of suggested Hill consultations on the Medicare issue. I think the following steps might make sense:

Senate

- Daschle Medicare policy group - I think the next step is for you to figure out with Daschle which Senators to include and how to proceed.

- Finance Committee Democrats - We have had several staff meetings and virtually all have been scheduled. I assume your office will schedule the meetings with Senators, with the goal of doing as many as possible before the April 20 committee briefing for Senators with outside experts. HHS would be grateful to have one person included in those meetings, including the Secretary if you want her.

- Other Senate Outreach - I would suggest that we schedule meetings with staff first, then regroup and see whether meetings with any of the Senators makes sense. We could cover the staff faster using two briefing teams (each with WH, OMB, HHS, and Treasury reps).

- Select Senate Republicans - I would suggest meetings with staff of these six Senate Republicans. We are unlikely to turn them against Breaux-Thomas, but we can raise serious concerns about its effect on beneficiaries and rural areas and gather intelligence about how Roth and the leadership might proceed.

House

- House Leadership Group - Discussion with staff Wednesday (Janet was there) indicated that another principals meeting should wait until our plan is further along.

- Medicare Task Force - Staff thought a members briefing on Breaux/Thomas would be helpful. We should do this next week if possible.

- Commerce Committee Staff - Dingell's staff has asked for a members briefing on Breaux/Thomas. Also should do next week if possible.

- Caucuses/Groups - Janet and I discussed offering member briefings for the CBC and CHC, but assume we would do staff briefings instead. I think it is important to do member briefings for the Blue Dogs and New Democrats as soon as possible.

- Select House Republicans - I would suggest staff meetings with these seven House Republicans, mainly to test support for Breaux/Thomas and to gather intelligence.

- On Hold - Committee staff indicated Wednesday that briefing for Ways and Means Democrats was not necessary. Outreach to the individual members listed will be important for our plan roll-out, but Gephardt's staff has indicated that they would prefer group consultations for now.

Cc: Janet Murguia
Chris Jennings

Rich

Richard Durbin
UNITED STATES SENATOR ■ ILLINOIS

FAX

TO: Chris Jennings

OFFICE:

FAX NO: ( ) 456-5557

FROM: Dr Anne Marie Kelly

PHONE: (2 0 2) 224-8464

DATE: April 22, 98

PAGES *(including this cover sheet):* 3

NOTE: Northwestern's inpatient margins for FY98 are close to zero. They are one of the wealthiest hospitals in Illinois. Under BBA they are closing their skilled nursing facilities. They have scope for revenue transfers (endowment etc) Mt Sinai + others do not. The Illinois hospitals are asking for surplus funds to go to Medicare.

RICHARD J. DURBIN
ILLINOIS

COMMITTEE ON THE JUDICIARY

COMMITTEE ON
GOVERNMENTAL AFFAIRS

COMMITTEE ON THE BUDGET

United States Senate

Washington, DC 20510–1304

February 1, 1999

364 RUSSELL SENATE OFFICE BLDG.
WASHINGTON, DC 20510–1304
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TTY (202) 224–8180

230 SOUTH DEARBORN, 38TH FL.
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SPRINGFIELD, IL 62703
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SUITE 414
MERCANTILE BANK OF SOUTHERN ILLINOIS
123 SOUTH TENTH STREET
MT. VERNON, IL 62864
(618) 244–7441

President William Jefferson Clinton
The White House
1600 Pennsylvania Ave.
Washington, D.C. 20500

Dear President Clinton:

I am writing to lodge my strong opposition to your budget proposal that would cut more than $10 billion from Medicare hospital payments over the next five years.

The Balanced Budget Act of 1997(BBA) has already cut over $44 billion from hospitals' Medicare payments over this time period. The Illinois Hospitals and Health Systems Association (IHHA) estimates that Illinois hospital payments will be cut by $1.8 billion by the BBA. Of the $1.8 billion cut, IHHA estimates that $1 billion will come from inpatient care payments. Furthermore, the BBA cuts are more severe in years 2000 to 2002. Illinois hospitals estimate that they will see reductions of $439 million and $489 million in 2001 and 2002, respectively, due to enactment of the BBA. Therefore, the Administration's reported focus on the 1996 hospital margins would appear premature.

While the national average for profit margins in 1996 for inpatient Medicare services was 15 percent, the Illinois average was only 11 percent. Furthermore, the Illinois median was only 7.8 percent and nearly 25 percent of Illinois hospitals actually had negative Medicare inpatient margins for that year. These margins were achieved prior to enactment of the BBA. Illinois already has a large number of underserved areas. Further cuts may place excessive strains on the health care system, especially on those hospitals that are already finding it difficult to remain in business. This will jeopardize the ability of not only senior and disabled Illinoisans to access health care services, but also the communities at-large who rely on hospitals as an important part of the health care infrastructure.

Members of the Medicare Payment Advisory Commission (MedPAC) recently cautioned against reducing Medicare payments beyond BBA levels given the uncertainty of the impact that the already enacted cuts would have on access to care.

While I am generally very supportive of many of the Administration's proposals contained within the FY2000 budget, including those that help seniors with long-term care expenses and expanded access to the Medicare program, I believe it would be unwise for Congress to adopt these Medicare cuts this year.

Sincerely,

Richard J. Durbin
United States Senator

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

99 MAR 26 AM 7:35

March 24, 1999

The Honorable Richard J. Durbin
United States Senate
Washington, DC 20510

Dear Senator Durbin:

Thank you for your letter expressing concerns about provisions related to hospital payments in the President's FY 2000 Budget. The President asked me to respond directly to your letter.

First, let me assure you that the Administration would not propose a Medicare policy change that we thought would hurt beneficiaries who require inpatient hospital services or be unfair to inpatient hospitals. We are concerned, however, that Medicare is overpaying for inpatient hospital services. Although the Medicare Payment Advisory Commission (MedPAC) does not recommend hospital update changes at this time, their data continue to indicate that hospitals have earned and will continue to earn record-high inpatient margins from their Medicare patients. The Budget's proposals reflect the Administration's concern that Medicare payments be fair, adequate, and not excessive. We will carefully review the concerns that you and others have raised regarding the potential impact of these proposals.

The President remains committed to working with the Congress to strengthen the Medicare program for the future. However, we also believe that the Administration has a responsibility to ensure that Medicare payments are fair, adequate, and not excessive and that the program remains strong and solvent to protect our beneficiaries. The Administration will continue to act upon its responsibilities through legislative proposals and regulation.

We appreciate your concerns and look forward to working with you in this legislative session to ensure that Medicare beneficiaries receive the best possible care in a fiscally responsible manner.

Sincerely,

Jacob J. Lew
Director

The Financial Outlook for Medicare

Testimony before the
Senate Finance Committee
on May 5, 1999

by

Richard S. Foster, F.S.A.
Chief Actuary
Health Care Financing Administration

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medicare program. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the Nation's second largest social insurance program—one that is a critical factor in the income security of the our aged and disabled populations.

The financial outlook for the Medicare program has improved dramatically since 1997 as a result of the Balanced Budget Act of 1997, together with recent strong economic growth, moderate increases in health costs generally, and continuing efforts to combat fraud and abuse. Even so, there remains a serious imbalance between long-range income and expenditures for the Hospital Insurance (HI) trust fund and growth rates for Supplementary Medical Insurance (SMI) benefits are expected to continue to exceed growth in the Nation's economy.

Background

Chart 1 summarizes the enrollment, covered services, and financing provisions of the Medicare program. Information is shown separately for the HI and SMI programs, also known as "Parts A and B," respectively. As indicated, roughly 39 million people were eligible for Medicare benefits in 1998. HI provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth.

Only about 22 percent of HI enrollees received some reimbursable covered services during 1998, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incur reimbursable SMI costs because the covered services are more routine and the annual deductible for SMI is only $100.

The two parts of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.[1] Of the total FICA tax rate of 7.65

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[1] Federal Insurance Contributions Act and Self-Employment Contributions Act, respectively.

percent of covered earnings, payable by employees and employers, each. HI receives 1.45 percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. Other HI income includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums ($45.50 in 1999) that cover about 25 percent of program costs. The balance is paid by general revenue of the Federal government and a small amount of interest income.

The HI tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, SMI premiums and general revenue payments are reestablished each year to match estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

Each part of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the financial projections contained in the Board's 1999 report to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10 years) and a "long range" (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

Short-range financial outlook for Hospital Insurance

Chart 2 shows past income, expenditures, and trust fund assets for the HI program and projections through 2015. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year are intended to be roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities. The Board of Trustees has recommended maintaining assets equal to at least one year's expenditures as a contingency reserve.

During 1990-97, HI expenditures increased at a faster rate than HI income. Expenditures exceeded income by $2.6 billion in 1995, $5.3 billion in 1996, and $9.3 billion in 1997. Prior to the Balanced Budget Act, this trend was expected to continue, with costs growing at about 8 percent annually, against revenue growth of only 5 to 6 percent. The 1995-97 shortfalls were met by redeeming trust fund assets, but in the absence of corrective legislation assets would have been depleted in about 2001. The Medicare provisions in the Balanced Budget Act were designed to help address this situation and, as indicated in chart 2, these changes significantly reduce the

the Balanced Budget Act provisions. After 2002, however, cost rates would increase steadily and accelerate significantly with the retirement of the baby boom, beginning in about 2010. Closing the HI deficit over the first 25 years would require either an 11-percent reduction in benefits or a 12-percent increase in income, or some combination, starting immediately. Over the full 75-year period, the adjustments would have to be considerably greater.

The effect of the baby boom's retirement on Social Security and Medicare is relatively well known, having been discussed at length for more than 25 years. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary, as shown in chart 5. Currently, this ratio is 3.9 workers per beneficiary. With the advent of the baby boom's retirement, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to 2.2 in 2030 and 2.0 in 2050 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 17.4 years currently, with an estimated further increase to over 20 years at the end of the long-range projection period. Medicare costs are also sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than younger persons. Thus, as the beneficiary population ages over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

The key factors underlying past and projected increases in HI expenditures are summarized in chart 6. Aggregate cost increases have been factored into (i) growth in the number of beneficiaries, (ii) increases in general inflation, as measured by the Consumer Price Index, and (iii) all other factors, reflecting per capita increases in the utilization of health services and the "intensity" (or average complexity) of such services. Through the early 1980s, general inflation was a major contributor to growth in HI costs. The "all other" category has seen major swings in the past, from average annual increases of as much as 6 percent to as little as 0.7 percent.

Under the intermediate projections, the impact of the baby boom's retirement clearly shows up in its effect on beneficiary growth rates. The Trustees project a fairly constant rate of inflation at about 3.3 percent annually. Projected growth in the "all other" category varies significantly, reflecting the net impact of several factors. Initially, residual growth rates are low due to the impact of the Balanced Budget Act. After 2002, utilization is expected to reaccelerate, although not as severely as in past years, due to the new prospective payment systems mandated by the Act. Future demographics will also play a role: as an influx of 65-year-old baby boomers arrives, average per capita utilization will actually decrease temporarily, as the average age of beneficiaries declines. As the baby boom generation ages, however, their utilization will increase and drive up residual HI growth rates overall.

A final factor affecting the residual growth rates shown in chart 6 is an assumption that health costs cannot continue to grow indefinitely at the high rates frequently experienced in the past. A simple extrapolation of the past quickly leads to a situation where Medicare alone would represent a substantial portion of total gross domestic product—an untenable and unrealistic situation. For this reason, residual growth rates are purposely assumed to gradually moderate toward the end of the first 25-year projection period. This assumption has been used for many years and has been found appropriate in the past by independent panels of expert actuaries and economists. More recently, however, it has received considerable criticism. Accordingly, I have asked my staff to carefully review the long-range Medicare growth assumptions. In addition, the Board of Trustees is convening a new expert panel for the purpose of reviewing the Medicare trust fund projections. We will also ask this group to review the long-range growth assumptions.

Financial outlook for Supplementary Medical Insurance

Chart 7 presents estimates of the short-range outlook for SMI and is generally similar to the information presented in chart 2 for the HI program. Two key differences stand out: First, the income and expenditure curves for SMI are nearly indistinguishable in the future. As noted previously, SMI premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, the program will automatically be in financial balance, regardless of future program cost trends. The second difference is the relative level of trust fund assets. Since financing is reset frequently, a lower level of assets can suffice for contingency reserve purposes.

The primary concern for SMI is the rapid rate of growth in benefits. SMI costs grew by 41 percent over the last 5 years, exceeding the growth in the nation's gross domestic product (GDP) by 9 percent. Similar growth is projected for the short-range future. Although the Balanced Budget Act contained a number of provisions designed to reduce the rate of growth in SMI expenditures, their impact is more than offset by two other factors. First, the Act specified that home health services not associated with a prior stay in an institution were to be converted to Part B benefits and paid for by the SMI trust fund (phased in over several years). In addition, the Act provides for several significant new preventive or "screening" benefits, such as colorectal examinations, not previously covered by Medicare. As a result, SMI costs are estimated to increase somewhat as a result of the Balanced Budget Act.

The increase in SMI costs is offset by additional premium revenue under a provision to maintain the SMI premium at the level of 25 percent of expenditures. Prior to the Balanced Budget Act, premium increases would have been limited to the Social Security cost-of-living adjustment (COLA) and, over time, would have represented a declining share of total costs. The Balanced Budget Act makes permanent the current relationship between premium revenue and total costs.

The long-range cost of SMI (shown in chart 8 as a percentage of GDP) is expected to follow the same general pattern seen previously for HI. In contrast to HI, these costs will automatically be met through enrollee premiums and general revenues of the Federal government. Policy makers remain concerned about continuing rapid growth in SMI expenditures.

Conclusions

In their 1999 report to Congress, the Board of Trustees notes the substantial improvements in the financial outlook for Medicare that have come about as a result of the Balanced Budget Act of 1997, together with recent strong economic growth and relatively slow growth in health costs generally. But they emphasize the continuing financial pressures facing Medicare and urge the Nation's policy makers to take further steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future. Today's relatively favorable conditions could change, accelerating the expected return to deficits in the HI trust fund. Moreover, the earlier solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

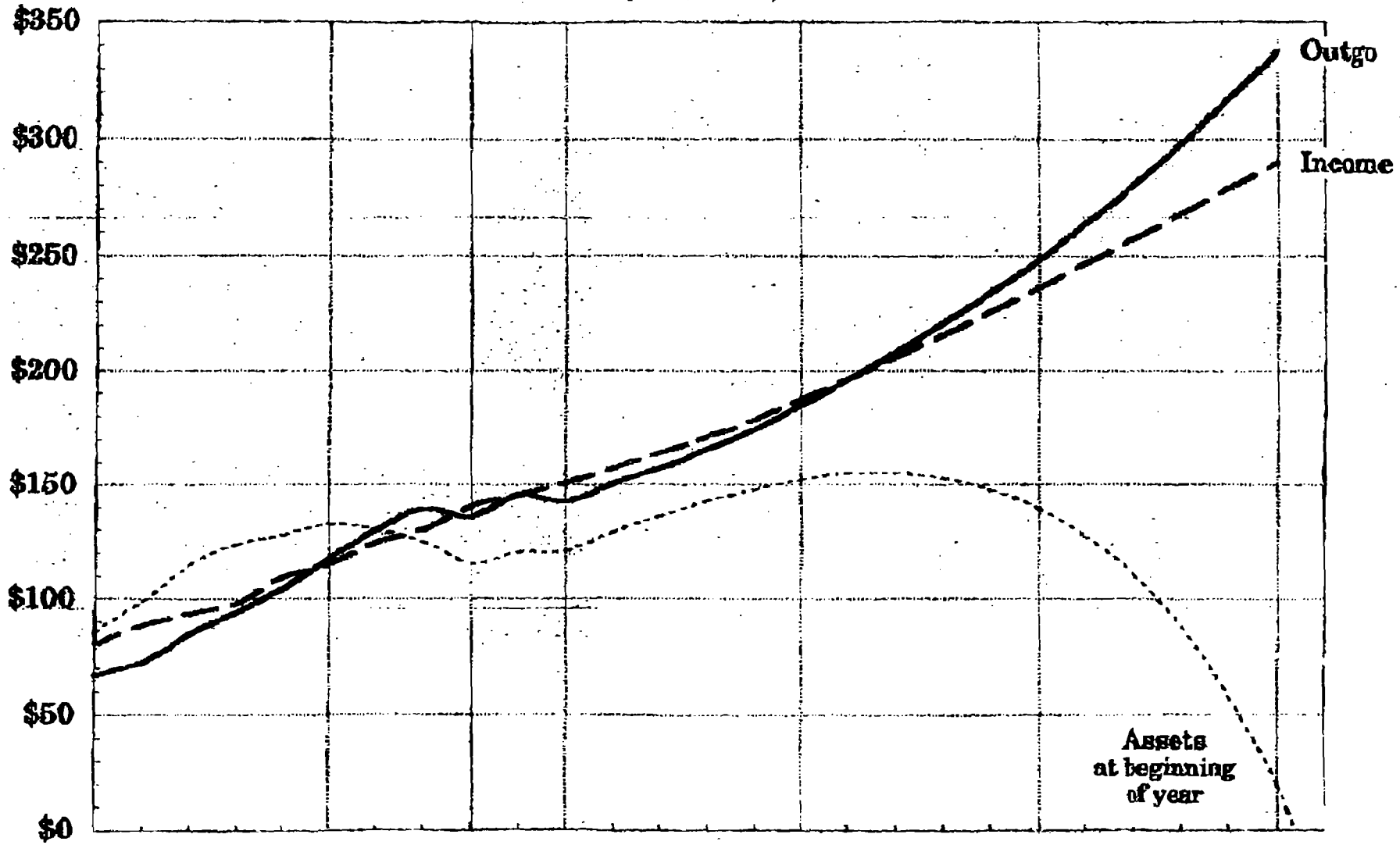
I concur wholeheartedly with the Trustees' assessment and pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine effective solutions to the remaining financial problems facing the Medicare program. I would be happy to answer any questions you might have on Medicare's financial issues.

Chart 1—Medicare enrollment, benefits, and financing

	Hospital Insurance (HI)	Supplementary Medical Insurance (SMI)
Enrollment in CY 1998:		
Total	39 million	37 million
Proportion with services	22%	87%
Benefits*	Inpatient hospital care Skilled nursing care Home health care (post-institutional) Hospice care	Physician services Outpatient hospital services Home health care (general) Other services, e.g. • Diagnostic tests • Medical equipment • Ambulance
* Subject to certain deductible and coinsurance requirements		
Financing	HI tax on covered earnings: • 1.45% payable by employees and employers, each • 2.90% payable by self-employed • Following elimination of HI contribution base (effective 1994), HI tax applies to all earnings in covered employment Revenue from taxation of OASDI benefits (portion between 50% & 85%)	Premiums paid by enrollees in 1999: • $45.50 per month for all enrollees • Covers 25% of costs General revenue transfers in 1999: • $139.10 per month for aged persons • $160.50 per month for disabled • Covers remaining 75% of costs

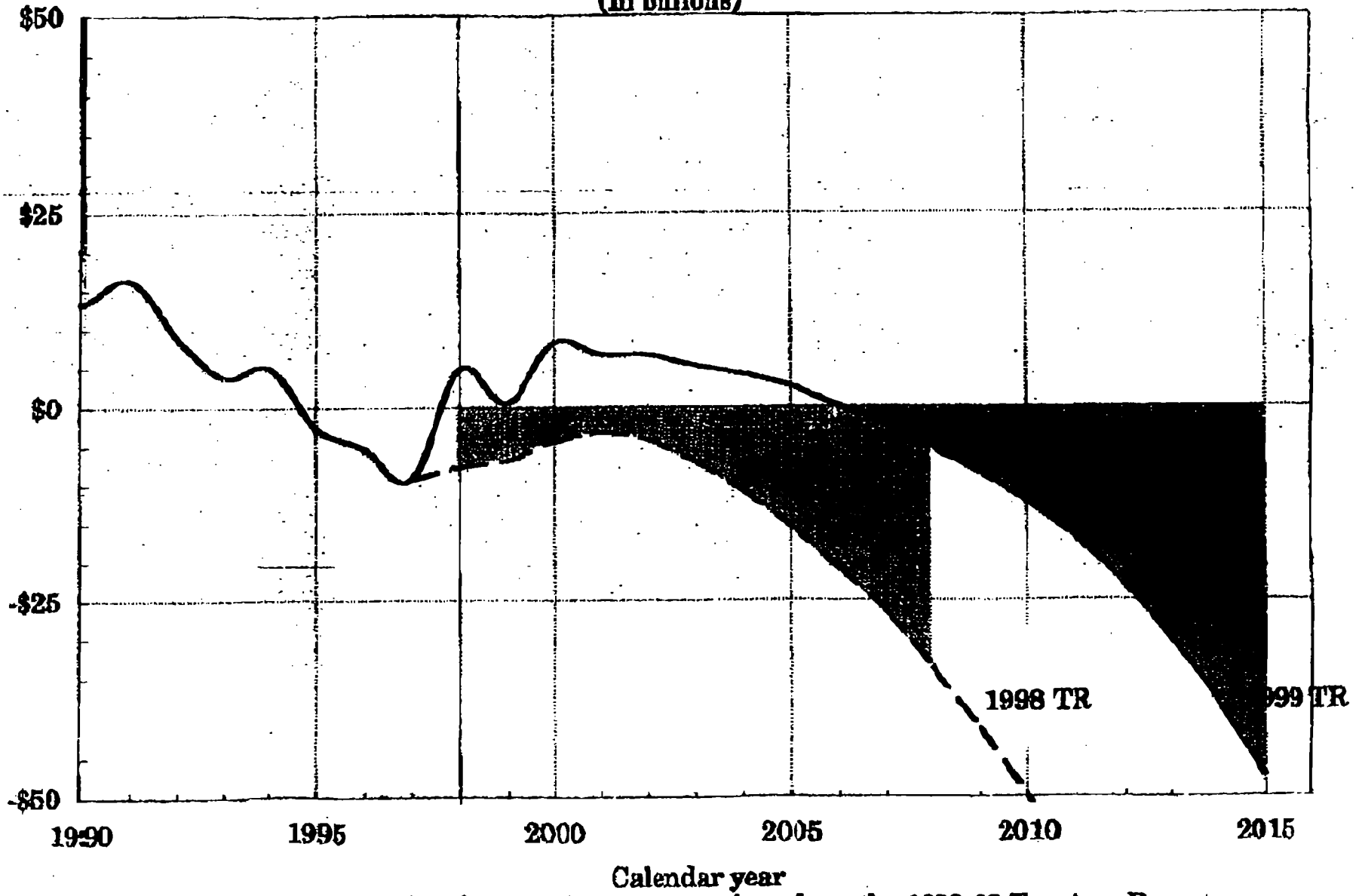
Chart 2—HI income, outgo, and trust fund assets

(In billions)



Note: Projections are based on the intermediate assumption from the 1999 Trustees Reports.

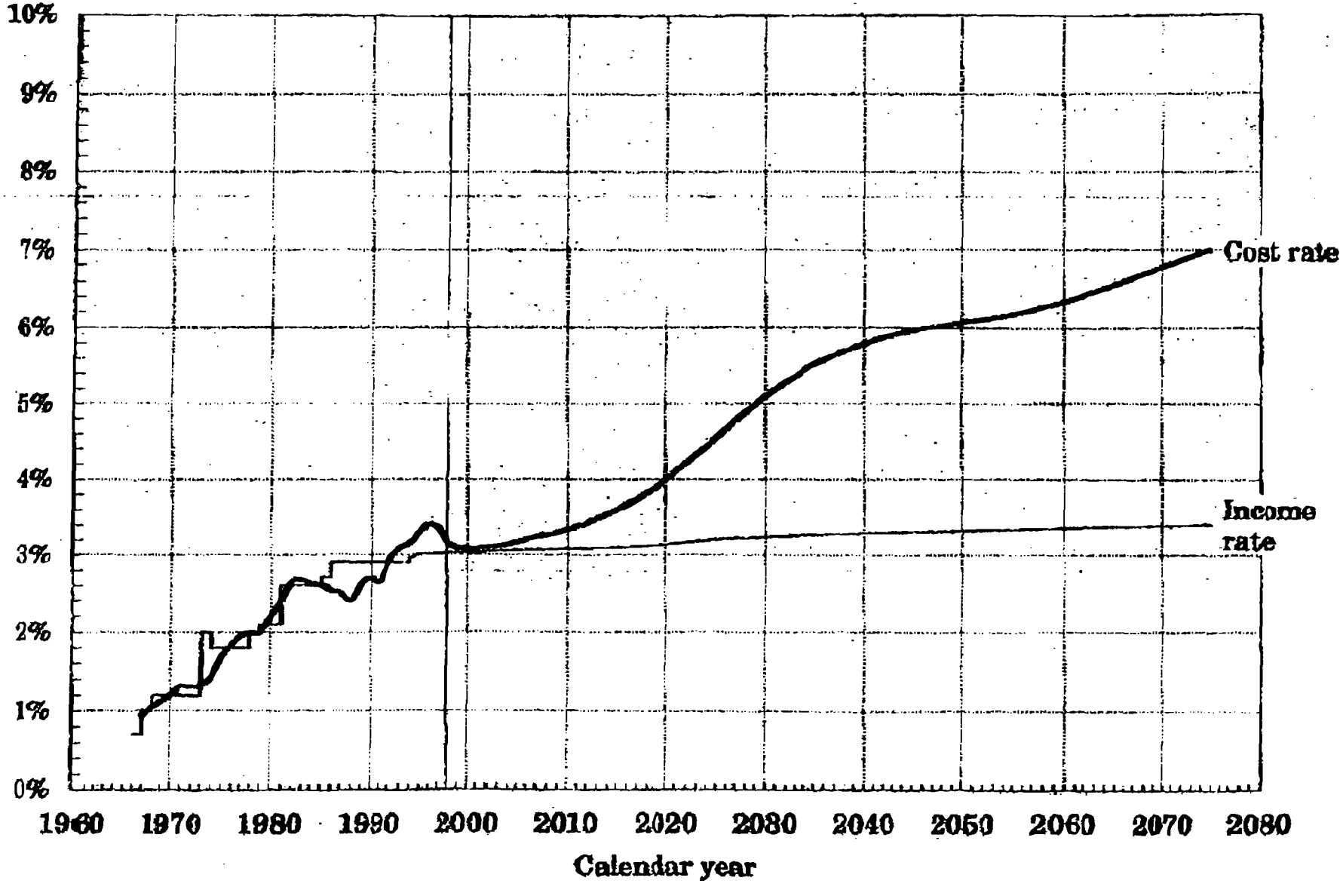
Chart 3—Net increase in HI trust fund assets, 1998 vs. 1999 Trustees Reports



Note: Projections are based on intermediate assumptions from the 1998-99 Trustees Reports.

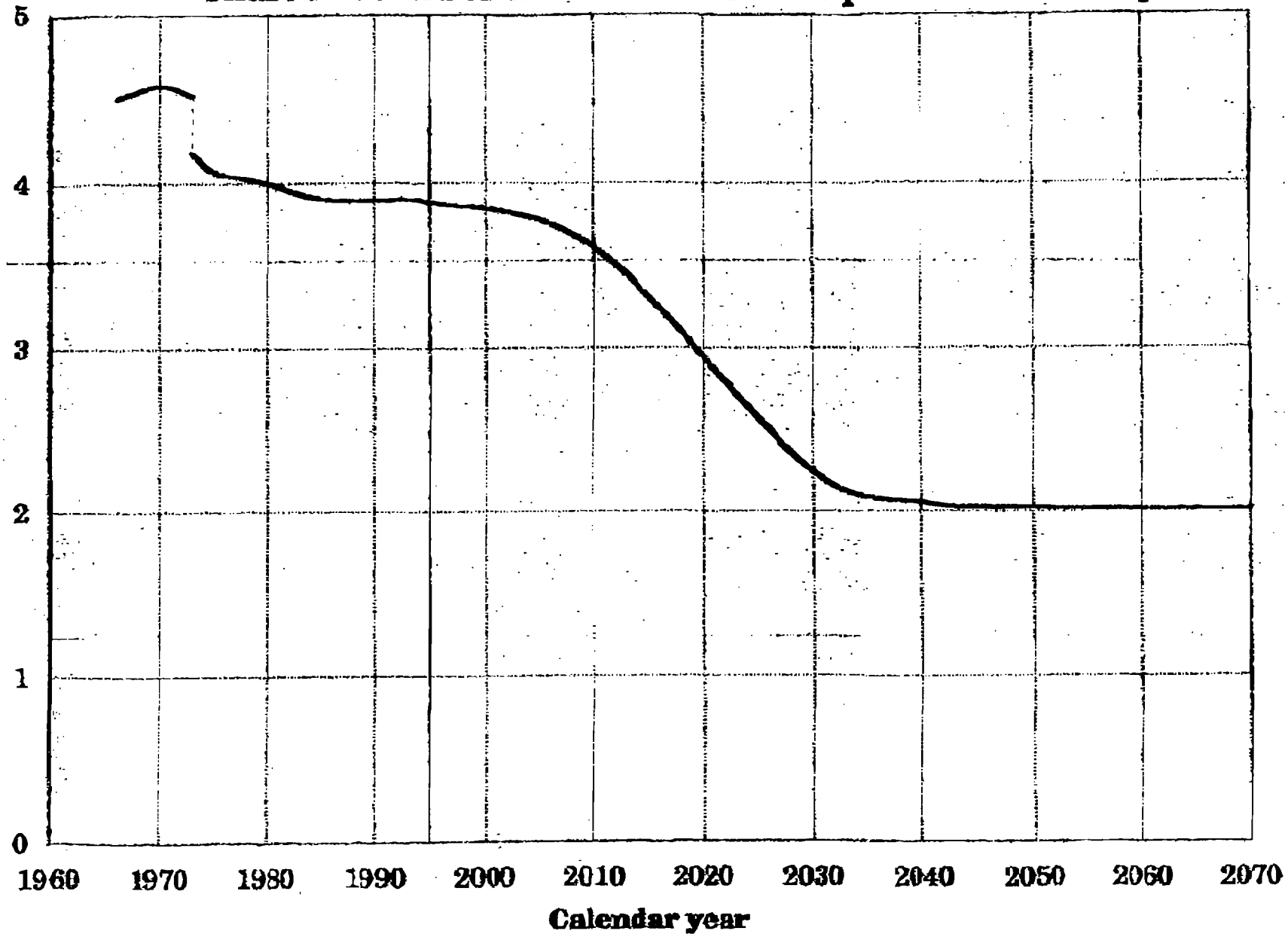
Chart 4—Long-range HI income and cost rates

(As a percentage of taxable payroll)



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

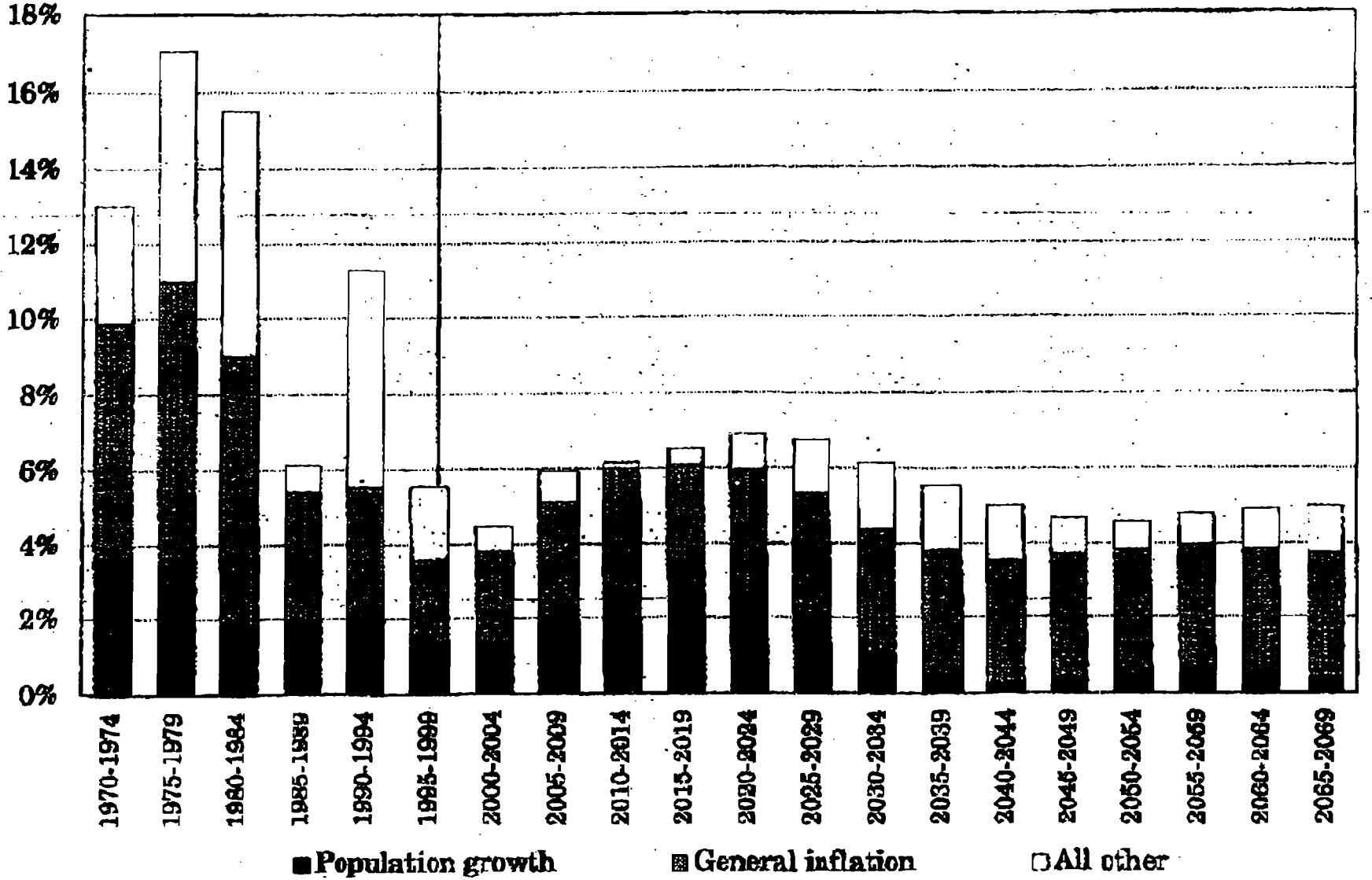
Chart 5—Number of covered workers per HI beneficiary



Note: Projections are b on the intermediate assumptions from the 1999 Trustees Reports.

Chart 6—HI expenditure growth factors

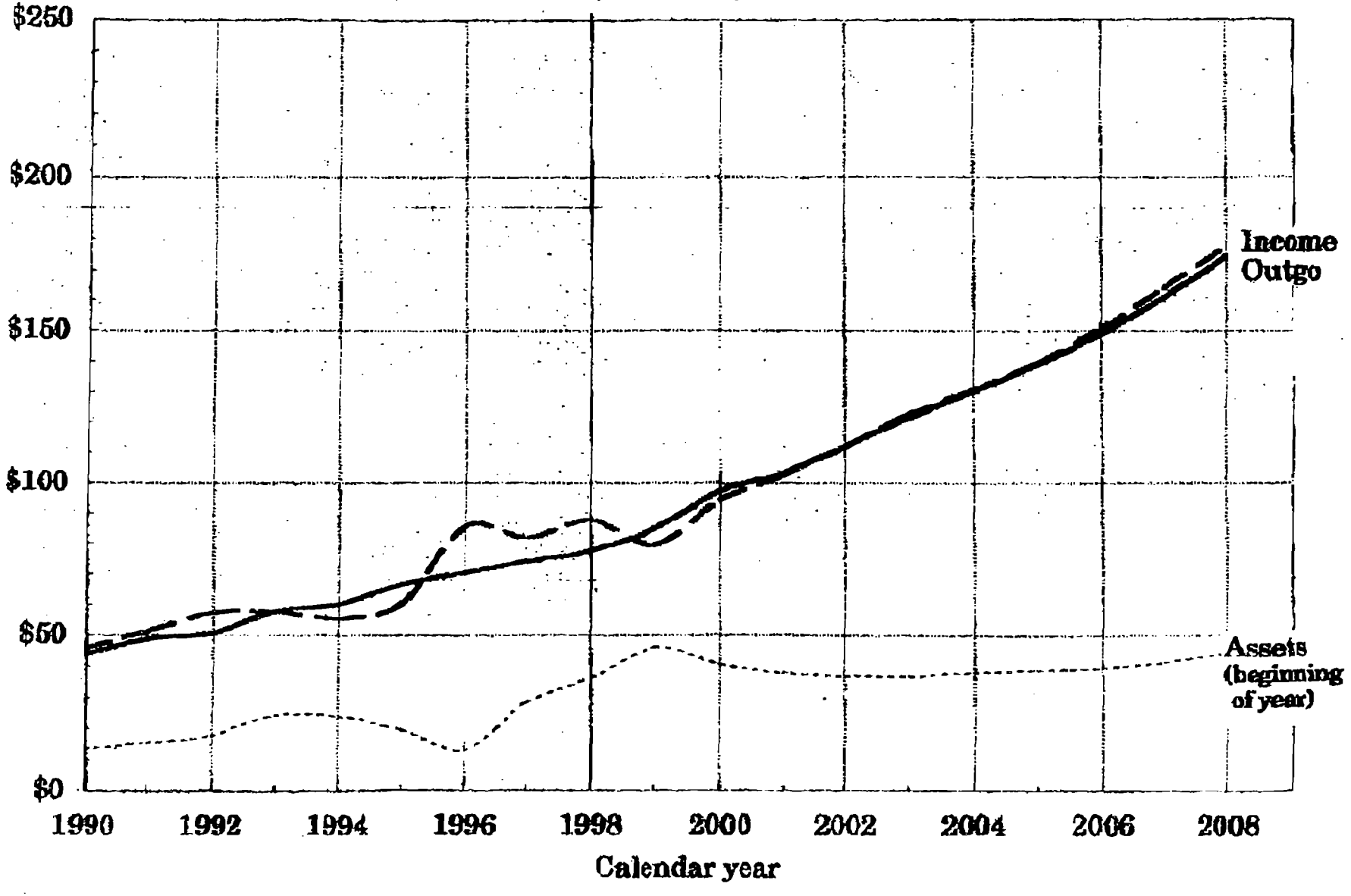
(average annual increase over 5-year periods)



Note: Projections are based on the intermediate set of assumptions from the 1999 Trustees Reports.

Chart 7—SMI income, outgo, and trust fund assets

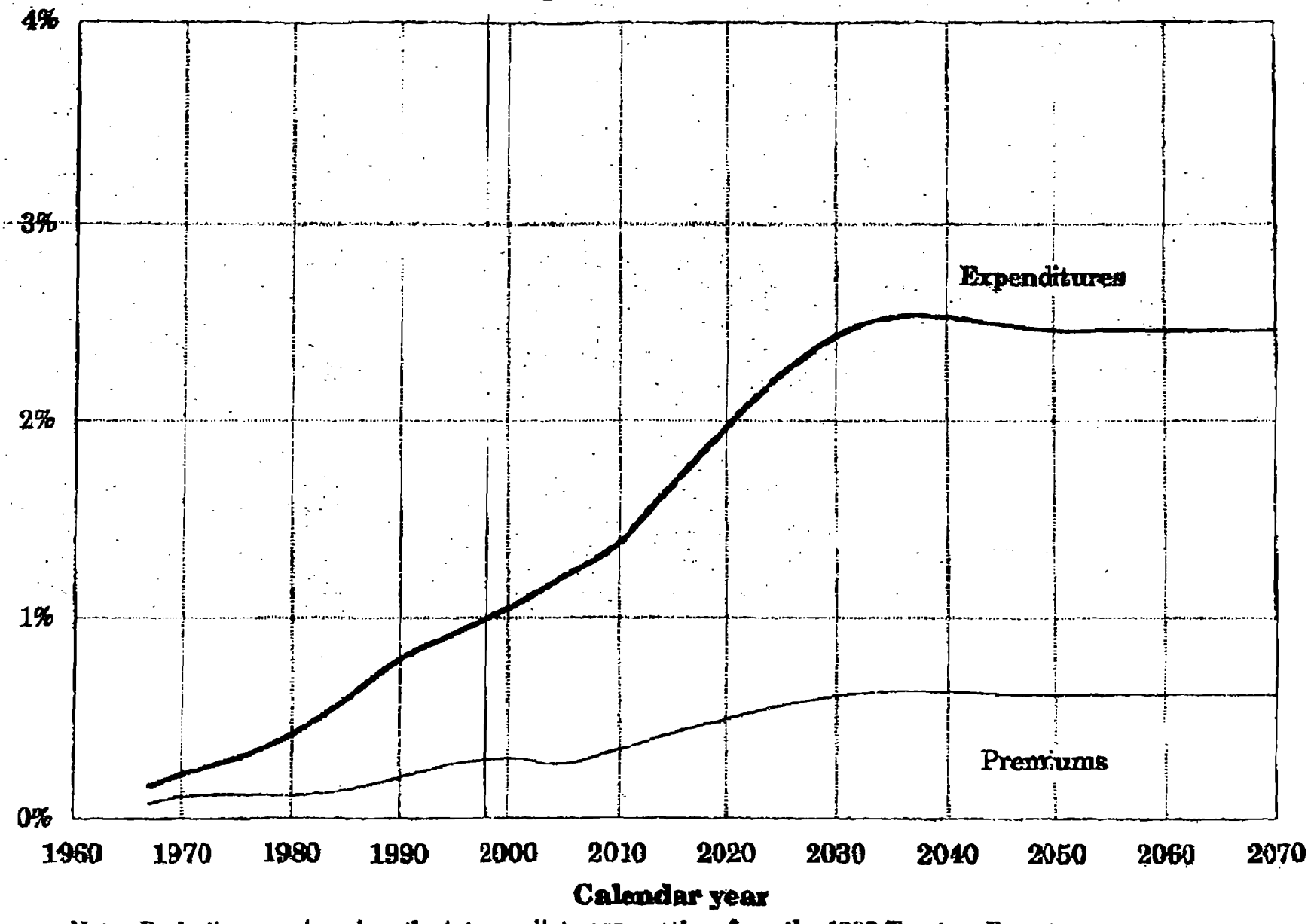
(In billions)



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

Chart 8—SMI expenditures and premium income

[as a percentage of Gross Domestic Product (GDP)]



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

DATE: 5-07-99

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REMARKS:

Please distribute to:
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United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510-6200

May 5, 1999

The Honorable William V. Roth, Jr.
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

We understand that you are considering whether the Finance Committee should mark up the tax title to S. 300, the Patients' Bill of Rights Plus Act, as reported by the Committee on Health, Education, Labor and Pensions (HELP). We write to express our serious reservations about this legislation, and to state our opposition to taking action on such a bill in the Finance Committee at this time.

We are concerned that Finance Committee action on this legislation may adversely affect the prospects for enacting a meaningful patient protection bill this year. S. 300 was reported by the HELP Committee on a straight party-line vote. Addition of a tax title, even if it were to avoid controversial tax proposals, would not avert the likelihood of gridlock when the bill reaches the Senate floor. Yet the tax title of S. 300 includes a provision for expansion of Medical Savings Accounts, which are highly controversial and have in recent years been the subject of partisan divisions in the Finance Committee and on the Senate floor.

We want the Congress to consider and enact meaningful patient protections, a goal we believe you share. To accomplish this objective, Senators must work together on a bipartisan basis to craft a set of patients' rights that will benefit health care consumers and not jeopardize the availability of health care to all Americans. Perhaps the members of the Finance Committee offer the best chance for developing consensus legislation. Our members should have the opportunity to address the underlying patient protection provisions of the bill. To ignore our responsibilities in that regard could jeopardize the Committee's jurisdiction in the future.

In our view, marking up a tax title to append to the HELP Committee bill will make it more difficult for the Senate to reach bipartisan agreement on this important issue. If the Finance Committee is to consider a managed care bill, then we would urge you to schedule a markup of comprehensive legislation that can pass the Senate and be signed into law.

Sincerely,

Max Baucus

[redacted] Patrick Moynihan

John Breaux

John D. Rockefeller IV

Bob Graham

Kent Conrad

Robert Kerrey

Richard Bryan

Charles S. Robb