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Background on Prescription Drug Issues

Prescription drugs account for 6.6% of health care expenditures for the elderly, but drug treatment is one of the most rapid areas of technological change. Most new drugs today are the result of advances in many branches of molecular biology, including new insights into the molecular mechanisms of disease processes, and the capacity to modify precisely existing agents in a therapeutic class (e.g., to influence side effects or ease of use). If anything, most experts expect the rate of innovation in drug agents to increase, so that the recent rapid spending growth on drugs (8% per year) is likely to continue or even accelcrate – even as a growing number of existing drugs come off patent and see their prices fall.

This brief focuses on three issues related to adding a drug benefit to Medicare:

(1) Drug Benefits in Medicare: What drug benefits are currently used by Medicare beneficiaries, how are they structured, and how might a Medicare benefit be structured?

(2) Drug Spending and "Crowdout" of Private Plans: What are drug expenditures for Medicare beneficiaries and their distribution between the private and public sectors, and how much might a Medicare drug benefit "buy out thc base" as well as induce additional utilization?

(3) Controlling Drug Costs through Benefits Management: How are drug benefits managed in the private sector, and how might these models be adopted for a Medicare drug benefit?

1. Drug Benefit Structure

Drug Benefits for Medicare Beneficiaries Today

Source	Share	Coverage
Medicaid	13%	Nominal copayments and few coverage limits, but formularies often restrict coverage and use of costly brand drugs.
Medicare HMO	6%	Mostly "front-end" benefit: low copayments, but total benefit capped (most commonly at $1,000) in over 60% of plans, and such limits are becoming more common. Generally use benefits management (see below) to limit drug costs.
Medigap	10%	Mostly "front-end," limited benefit: the standardized Medigap plans require $250 deductible, 50% coinsurance, cap benefits at either $1,250 or $3,000 per year. Due to adverse selection, the drug benefit in Medigap adds $1,000 or more to the premium, so these plans provide only limited insurance. However, they can help seniors buy drugs at lower negotiated costs.
Employer-provided Supplemental Insurance (ESI)	29%	Vary in generosity, but most apparently provide coverage similar to that for privately-insured workers, which is relatively generous by Medicare standards (no coverage limits, small or moderate copayments).
Combination	7%	Changed source of coverage during the year.
No Coverage	**35%**	

The beneficiary shares above are for drug coverage of different types in 1995. Since then, the number of beneficiaries enrolling in HMOs, which have mostly offered limited drug benefits, has doubled. However, an increasing share of HMOs are reducing the generosity of their drug benefit, increasing beneficiary premiums, or dropping the drug benefit. The share of beneficiaries covered by supplemental policies from former employers that include prescription drugs is also declining, and beneficiary payments for the coverage that is offered are rising. Finally, the stability of the Medigap market is open to question, as the price of plans that offer drug benefits has continued to rise. In sum, even those who now have coverage that might be similar to what Medicare would offer would gain financial and benefit security from

The following two moderate drug options illustrate the kinds of benefit packages that Medicare might offer:

Capped option: For example, this plan might include a $250 deductible (or with drugs counting toward the overall deductible), "standard" copays (e.g., $7 for a generic and $15 or 20% for an on-patent prescription), a $1,000-$1,250 limit on benefits, and premiums covering 50% of costs. HCFA actuaries expect that all beneficiaries would take it up, and that it might cost on the order of $40B over 5 years.

Pros: Would be preferred by most beneficiaries, who do not have nor expect very high prescription drug expenditures.

Cons: No catastrophic protection for those with the highest drug costs.

Catastrophic option: High deductible but low out-of-pocket payments thereafter; 50% premium. The deductible would have to be very high to limit program costs – well over $1,000. (Estimates by the HCFA actuaries suggest that such a catastrophic benefit with a $1,000 deductible but no further cost sharing might cost 50% more – or nearly $60 billion over 5 years)

Pros: Provides relief for those facing the greatest burden of prescription drug costs.

Cons: Would benefit far fewer beneficiaries. Since high drug expenditures are generally associated with chronic disease and are therefore predictable, probably would not be taken up by most beneficiaries, leading to adverse selection that could worsen the budgetary implications.

2. Distribution of Drug Expenditures and Potential for Crowd-Out

Expenditures for drugs by Medicare beneficiaries in 1995 totaled $22 billion. The first column of the Table below summarizes the distribution of this spending. Roughly one-fourth ($5.5 billion) was paid out-of-pocket by those with no drug coverage, one-fourth was paid out-of-pocket by those with drug coverage (both individually-purchased and employer-provided Medigap), and one-half ($11 billion) was paid by insurers. Of this $11 billion, one-half was ultimately paid by government sources (primarily through Medicaid and the tax expenditure on employer-provided health insurance), with the rest coming from premiums paid by beneficiaries ($3 billion) and employers ($2.5 billion).

The second column presents a comparable estimate of what drug expenditures might have been if a capped Medicare benefit like that described in Section 1 had existed in 1995. HCFA actuaries have indicated that such a benefit would be taken up by essentially all beneficiaries (due to the 50% subsidy), would have an actuarial value of approximately $200 (the 50% of the premium paid by the government), and thus would have started out costing the program about $6.0 billion. (Both columns could be scaled up proportionally to generate more current estimates.) The column illustrates the likely implications of such a universal benefit: how much of the $6.0 billion is likely to crowd out private employer spending, to offset beneficiary out-of-pocket spending, and to represent new spending on drugs?

Approximate Annual Payments for Drugs by Source (1995 $Billions)

	Current Distribution	Capped Drug Benefit
Medicaid (Federal + State)	2.6	2.6
Medicare HMO / Other Programs	1.0	1.0
Tax Expenditure on Employer-Provided Ins.	1.9	1.2
Medicare Drug Benefit		6.0
Total Government	**5.5**	**10.8**
Beneficiary Out-of-Pocket Costs		
Had Drug Coverage	5.5	5.0
Had No Drug Coverage	5.5	2.0
Beneficiary Premium Contributions		
Had Employer-Provided Insurance	1.0	1.0
Had Medigap / Switched	2.0	1.0
Had No Coverage	0	2.5
Total Beneficiary	**14.0**	**11.5**
Employer Premium Contributions	2.5	1.2
Total Employer	**2.5**	**1.2**
Total Drug Expenditures	**22.0**	**23.5**

These key points of the Table include:

- The first key point is that the incremental cost to the government of adding this drug benefit to Medicare ($5.0 billion) is less than the increase in Medicare expenditures ($6.0 billion). Though the program would provide some coverage that beneficiaries now get through former employers, it would simultaneously reduce the tax subsidy for this employer-provided coverage ($0.7B). It would also reduce drug expenditures now paid by other federal and state health programs ($0.3B).

- Second, even under generous assumptions, the share of the additional government spending that "crowds out" private insurance is modest. Maximum crowd-out of existing private coverage would occur if all former employers who offer drug benefits changed their benefit to "wrap around" the new Medicare benefit, e.g. by buying the Medicare

benefit for their employees and possibly offering additional coverage beyond it.[1] In this case, the employer costs that would be shifted to Medicare are about $1.3 billion – only around 1/5 of the total and 1/4 of the incremental program cost. Actual crowd-out might be smaller, if some employers do not wrap around the Medicare benefit. Moreover, even the crowded-out employer drug payments are likely to be redirected to other forms of employee compensation.

- Most of the additional Medicare spending would offset current out-of-pocket payments by beneficiaries and pay for additional drug usage. While financing out-of-pocket payments by beneficiaries that would have occurred anyway might also be viewed as "crowd-out," it is worth remembering that a principal goal of this policy is to increase beneficiary financial security by reducing their out-of-pocket drug outlays through a reliable source of coverage.

- The "winners" from this standpoint include beneficiaries without any coverage now, who would save around $1 billion per year in out-of-pocket costs (net of premium payments) and who would probably consume more drugs because of the reductions in aggregate and per-unit out-of-pocket costs. (An increase in drug utilization on the order of $1.5 billion, or 7% of total spending, might be expected; this would be concentrated among those who currently lack drug coverage, and reflects the assumption that half of the difference in their per capita utilization is due to lack of insurance, with the rest due to selection.)

- The policy would also provide transfers of $1.5 billion to those with Medigap coverage now, who would start receiving both a 50% premium subsidy and somewhat more generous coverage (lowering their out-of-pocket costs).

- Spending for HMO beneficiaries who already have a drug benefit would probably not be much affected. Those who are enrolled in risk HMOs that offer prescription drug benefits might face modest reductions in out-of-pocket premiums and increases in coverage (if their current HMO benefit is more limited than the new benefit). Many HMOs do not charge significant beneficiary premiums (beyond what they receive from Medicare) for a drug benefit similar to the capped benefit option. They may continue offering these benefits rather than have their enrollees receive drug coverage outside the HMO. If they dropped coverage, these beneficiaries would have to start paying 50% of the premium for their drug benefit – which could generate up to $0.5B in cost-shifting from the government to beneficiaries. However, because HMOs compete in benefits for Medicare enrollees (government premium contributions are fixed), these HMO cost reductions would probably be offset by increases in other benefits (e.g., preventive care, dental,

[1]If employers stopped offering altogether rather than paying the beneficiary premium, the savings in drug spending would be expected to go into other forms of employee compensation. In turn, the employees would use these higher wages to buy the new Medicare drug benefit, so the net effect is the same.

eyeglasses, etc.) Thus, our best guess is no significant change in government spending or net out-of-pocket payments for HMO beneficiaries who currently have prescription drugs.

- Introducing a capped Medicare drug benefit would probably not change total government drug expenditures on Medicaid enrollees substantially. But the actual division of dollars between Federal Medicaid, state Medicaid, and Medicare could change, depending on a number of factors. For simplicity these dollars are left in the Medicaid line, though it should also be noted that maintenance-of-effort requirements on the states and Medicaid payment of the 50% beneficiary premium would ensure that large portions of this public spending would not be transferred to Medicare.

These figures suggest that the total additional federal spending would primarily go to reduce existing beneficiary premium costs and out-of-pocket payments for the uninsured and underinsured ($2.5B or 50%); another $1.5B (30%) would represent new spending on drugs by beneficiaries with little or no drug insurance now, and around $1B (20%) would crowd out other private spending. These estimates do not reflect a comprehensive model of drug demand or of adverse selection in particular segments of current coverage. However, a more sophisticated model is unlikely to alter the basic conclusion that the vast majority of spending on the new drug benefit would reduce beneficiary out-of-pocket payments and permit additional drug use by seniors who cannot afford it now.

Composition of New Government Spending on Drug Benefit - Preliminary Estimates

	1995 $ Billions	Share of Net Program Costs	Share of Total Program Costs
Reductions in Out-of-Pocket Costs for Uninsured and Underinsured	2.5	47%	42%
New Spending on Drugs	1.5	28%	25%
Reduced Employer Contributions	1.3	25%	22%
TOTAL NEW GOVT. SPENDING	5.3	100%	
Reduced Tax Expenditures	0.7		12%
TOTAL MEDICARE COST	6.0		100%

3. Management of Drug Benefits

Could the costs of drugs in the drug benefit be reduced through benefits management? Many private-sector health plans use Pharmacy Benefit Managers (PBMs) to administer their drug benefit programs. In 1995, about 60% of Federal employees were covered by plans with PBMs, and their use is even more common among large managed care plans and large private employers. Such arrangements could be adopted in the Medicare benefit to encourage efficiency and avoid forcing the government to make decisions about what specific drugs are covered and how they should be priced, and to address concerns about greater direct government involvement in pharmaceutical markets. This section reviews how PBMs work and some of the recent research on their consequences for drug costs.

Sources of Drug Cost Savings. PBMs use a variety of mechanisms to control costs and ensure appropriate utilization, including:

- *Formulary Management.* Plans often provide financial incentives for enrollees to use generic versions of drugs when available, or encourage physicians and pharmacists to substitute generics when writing or filling prescriptions. Plans may also limit costs by excluding the most expensive on-patent drugs in a therapeutic class from their formulary, or list of covered drugs, and by negotiating volume-discount contracts that include only a few drugs in each therapeutic class.

  The following table, taken from a recent news article, provides an example of these beneficiary payments (and the recent trend toward more cost sharing) in an Oxford Health Plan in New York City. Captopril is the generic version of Capoten (the original, and still most popular, drug in the therapeutic class of acetylcholinesterase or ACE inhibitors). The other drugs are more recent entrants in this drug class which are still on patent, and which are marketed for their added benefits (e.g., less frequent dosing).

Blood Pressure Drugs - ACE Inhibitor Class	Price of One-Month Supply		
	Retail Price	1998 Plan Price	1999 Plan Price
Capoten	$95	n/a	50
Vasotec	35	10	35
Accupril	35	10	20
Monopril	30	10	20
Captopril (generic)	32	5	7

The bulk of the savings that PBMs offer appear to come from discounts they negotiate through outside retail pharmacies (as reflected in the table above) or through their own

retailing methods (e.g., the plans require prescriptions to be filled by mail, or at their own in-house pharmacies).

- *Mail-Order Discounters.* Some mail-order (and now internet-based) drug companies also offer discounts to seniors who do not have a drug benefit plan. These companies focus on high-volume users with chronic illnesses, typically by requiring a minimum of a 90-day prescription. Many plans provide financial incentives for beneficiaries to use mail-order prescriptions as well, and similar incentives might be adopted in a Medicare benefit.

- *Drug Utilization Review.* Improving information systems on drug use and patient health characteristics has permitted many retailers and plans to avoid adverse drug interactions and drugs that cause allergic reactions. In principle, these systems could be used to monitor physician prescribing patterns and the appropriateness of a patient's drug regimen, and to encourage physicians to change drug choices in order to reduce costs. Such utilization review and disease management applications have been implemented on only a limited basis to date, however, and have not necessarily reduced drug costs. For example, many plans use information systems to remind doctors to advise postmenopausal patients about the value of hormone replacement, or to assure that asthma patients are on a regular preventive regimen of inhaled corticosteroids. While these management systems have important health benefits and may reduce long-term health costs, they probably increase drug costs.

Evidence on cost impact of drug benefit management. PBMs are relatively recent developments, and few studies have examined their effects. Two studies are summarized below; both suggest that strong PBM programs could reduce drug expenditures by around 25%.

Source of Drug Expenditure Reduction	**Effect**
Grabowski and Mullins (1997)	
Negotiated Discounts through Formularies	5-15%
Generic Substitution	5-10%
Utilization Review	0-4%
Total Savings	14-31%
GAO Survey of FEHB PBMs (1997)	
Negotiated Discounts through Formularies	14-20%
Other Sources of Savings	6-12%
Total Savings	20-27%

In principle, beneficiaries could enjoy these savings even if they were below their deductible or over their benefit cap. Because negotiated discounts are the major source of PBM savings, however, it is possible that the average savings from retail prices could be smaller if all of the elderly were enrolled in PBM plans. The likely savings in overall elderly drug expenditures from widespread use of PBMs is also limited by the fact that many Medicare beneficiaries already use plans with PBMs, or mail-order discounters. Consequently, a reasonable *but conservative and preliminary* estimate of the overall effect of adopting PBMs for all Medicare beneficiaries is a 5-10% reduction in average drug prices paid. Using this estimate, total drug expenditures by Medicare beneficiaries would increase by 7% under a capped benefit plan, even though the quantity of drugs used by the elderly would increase by a larger amount, 10-20%.

Unresolved Issues for Medicare Reform

Issue	Breaux Plan 1/26/99	Issues / Options
Design of Premium Support		
Required Benefits	Benefit categories (e.g., hospital services) would be specified as FEHB does, but details are left for plans to choose – subject to approval of oversight board. Presumably current Medicare benefits are included.	Must maintain at least the benefits in Medicare today, plus a prescription drug benefit (below). Some question about whether certain benefits need to be specified in more detail (e.g., minimum length of stay for mastectomy) – though all plans are likely to be subject to Executive Orders on patients' rights, as Medicare and FEHB are now.
Drug Benefit	Exploring options (including Medigap mandate?). Republicans have expressed concerns about substituting public for private dollars, and fears of "government price regulation" of drug companies.	Must be included, but key questions on specifics: (1) Voluntary or mandatory: probably voluntary with significant beneficiary contribution to limit cost to program (e.g., 50% subsidy for premium); subsidizing premium limits adverse selection pressures but opt-in rules may also be needed (2) Front-end coverage (relatively low copays and/or deductibles and modest limit on total benefits per year, e.g. $1000-1500 with indexing) or catastrophic coverage (high deductible and/or copay, but no limit on benefits; fewer elderly benefit more) (3) Drug purchasing mechanism: Probably would rely on govt. contracts with private pharmaceutical benefit managers, who could manage formularies and negotiate favorable contracts, just as they do now for private insurance plans (4) Other design issues: Do deductibles and copays count toward overall plan limits? Income-related premium (e.g., no cost for current Medicaid beneficiaries, subsidies for others)? Strength of financial incentives for beneficiary to use generics and therapeutic equivalents, to reduce cost of plan?

Issue	Breaux Plan 1/26/99	Issues / Options
Premium Support Formula	For typical beneficiary, govt. pays a fraction of premium (88-90%) up to a premium "cap." Cap is equal to the national average premium (based on prior-year enrollments?); beneficiary pays full premium above this. At hearing, Breaux stated that average beneficiary share for current benefits will remain at current level (12%), but no written details on how to guarantee this support level.	Prefer explicit commitment to maintaining current level of support for current package of benefits. Need to specify how this would work in practice - e.g., 88% of premium of traditional fee-for-service (FFS) Medicare plan? What if FFS Medicare adds benefits like drug coverage or stop-loss protection?
Updates to Level of Premium Support	Unclear. Appears that premium cap would grow with national average premium (which in turn is likely to depend on how basic benefits are defined); also verbal commitment at hearing that standard beneficiary share for current benefits will remain at 12%.	Need explicit statement that premium support will increase with health care costs, to limit growth in beneficiary financial exposure. Could be tied to private-sector medical cost growth if concern that linkage to Medicare cost growth would encourage premium increases.

Issue	Breaux Plan 1/26/99	Issues / Options
Low-Income Protections / Income-Related Premiums	Medicaid, QMB, and SLMB eligibles pay no premiums up to cost of traditional FFS Medicare plan (and presumably no cost-sharing for Medicaid and QMB?). High-income beneficiaries – above $50K for couples and $40K for singles – pay higher fraction (25% not 10-12%) of premium up to national average, and apparently higher fraction (125% not 100%) for premium above average.	Need explicit statement of low-income protection, at least at level implied by current Breaux plan. High-income premiums may not raise much revenue and create administrative problems (few elderly households are high-income; would need asset tests to raise significant revenue). Democrats also have concerns about Medicare becoming a "welfare program." High subsidies for all income groups are needed to keep beneficiaries from dropping Medicare - Breaux plan provides this even for wealthy, who get 75% subsidy up to national average (around $5700 today). But making them pay more than 100% of premium above average would create this risk if average plan deteriorated. Details: Are higher premiums for high-income phased in? Will reported income of elderly respond?
Premium Bidding	Little detail - national bidding (national premium for traditional FFS Medicare; regional or national bids by private plans, with "geographic adjuster" for regional variation in health care costs) or regional/ local bidding.	Regional bidding (like FEHB), or national bidding with "appropriate" regional adjustment. Appropriate regional adjustment might include (a) adjustment for part of regional variations in Medicare costs or private insurance costs (but difficult to obtain reliable private insurance data at local level), (b) adjustment for regional variations in overall cost of living only (to reduce the large variation in Medicare utilization). Transition period needed if regional adjustments are small. Need to define relevant market in which competition will take place - FEHB regions? counties, as in Medicare AAPCC payments?

Issue	Breaux Plan 1/26/99	Issues / Options
Geographic Variation in Premium Support	Appears to establish a national schedule for premium support; suggests geographic adjustments limited to general cost differences, not the large variations in average utilization across regions.	Should account for regional variations in premiums, either by defining premium support cap on regional basis or by using regional adjuster as described above for bidding, so that beneficiaries in high-cost areas do not face large increases in out-of-pocket payments. At a minimum, national schedule should include a substantial transition period.
Risk Adjustment of Premiums and Government Payments	Says only that government contribution "will be adjusted for health risk and other factors."	Need more details on general principles. Can't appeal to FEHB experience, since FEHB premiums are not adjusted for beneficiary characteristics. Potential for risk selection is much greater in Medicare. Example: AAPCC "premium" payment in Medicare+Choice for 85+ year-old is over 50% higher than payment for 65-74 year-old. Issues include: (1) Beneficiaries should make similar premium contributions regardless of premium adjustment - 85-year old should not pay much more than 65-year old. (2) Risk adjustment method should be considered in context of other incentives / options to switch plans (i.e., open enrollment, financial incentives in premium support, allowed benefit variation). Goal is to minimize adverse selection pressures without recreating fee-for-service incentives. At this point, probably should (1) encourage further development of risk adjustment systems that do not depend on hospitalization, as HCFA is doing now; and (2) support adjustment of premiums and government contributions to protect quality and limit out-of-pocket cost of care for higher-cost beneficiaries.

Issue	Breaux Plan 1/26/99	Issues / Options
Default Choice/ Choice Assistance for Impaired Beneficiaries	Not addressed, except in that option to stay in Medicare FFS will be retained.	Less serious problem if support for 88% of FFS Medicare premium were guaranteed - assuring that there is a default option that is at least as good as their current insurance. May want to consider a counseling/ assistance system like that for elderly taxpayers, or support through through AOA offices.
Rural Beneficiaries with No/Limited Choice	Not addressed. Presumably regional bid would be FFS Medicare. Republicans have expressed concerns about HHS operating as unregulated monopoly.	Regional premium support might actually make rural beneficiaries worse off, since they generally live in lower-cost areas. Additional steps to assure quality and value of care in areas where traditional FFS Medicare has no competition?
Oversight Board	Similar to FEHB.	Some concerns about oversight/ accountability of independent Board, which would be charged with promoting welfare of beneficiaries but which would have no direct ties to them. But additional accountability mechanisms run risk of reducing Board independence from political pressures. Administration has endorsed an independent Board for managing Social Security funds, but the Medicare Board would have a much more complex task and much more discretion.

Issue	Breaux Plan 1/26/99	Issues / Options
Additional Benefits	Plans allowed to offer, with restrictions as in FEHB: oversight board "will be empowered to ensure that all benefit packages do not vary to the point that they produce ineffective or unfair competition." Benefit standardization noted as an "alternative design option."	Prohibiting additional benefits would encourage plans to compete on cost and quality, and would reduce opportunities for risk selection. This is done by most private "managed competition" plans. FEHB allows additional benefits, which provides more flexibility to respond to beneficiary demands. If additional benefits are allowed, may want to restrict the types of additional benefits that can be offered - to make choosing among plans less confusing for beneficiaries, and to avoid benefits that create significant risk selection problems. For example, variation in individual Medigap benefits is restricted today.
Plan Switching	Annual open enrollment period. One member suggested longer lock-in to limit selection.	Annual open enrollment period.

Issue	Breaux Plan 1/26/99	Issues / Options
Changes in the "Traditional" Fee-for-Service (FFS) Medicare Program		
Medicare FFS Option	Retained as an option in premium support; would continue to be managed by HCFA; could be modernized.	Must be retained and modernized.
HCFA Authority for "Modern" Management of FFS Medicare	HCFA would be given "management tools adopted by the private sector," including "enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, elective contracting, and preferred provider arrangements."	Support – both to rationalize benefit package and give HCFA powers needed to compete fairly. Should also allow HCFA to continue to develop quality assurance tools (and use them for payment). Much political opposition to exercising such powers under demonstration authority now – but new context of competition could reduce this opposition. If HCFA gets greater political independence, may still want mechanism for accountability/review, perhaps through oversight board.
Rationalize FFS Out-of-Pocket Payments	As example, proposes a combined deductible of $350, with 20% coinsurance for all but inpatient and preventive care, and 10% for home health.	Support rationalization. Breaux proposal is reasonable (similar to those considered by Administration) but could increase costs. How would deductible be indexed? Would payments for drugs be counted toward deductible? Home health currently has 0 copay.
Stop-Loss Protection	Not yet addressed in text – awaiting scoring results? Perhaps trade off $4,000 stop-loss limit for 20% inpatient coinsurance.	Catastrophic protection seems desirable on policy grounds, and may reduce demand for Medigap. But not a priority for most seniors, and much of the catastrophic insurance provided would go to hospitals that currently write off these charges as bad debt (covered by paying patients). If not included in FFS benefits, would it be allowed/prohibited in private plans?

Issue	Breaux Plan 1/26/99	Issues / Options
Medigap (Supplemental Insurance) Reform	No specifics, but states that "Medigap should be reformed to minimize the effects of first-dollar coverage on utilization and so that the price of Medigap policies reflect their true cost."	Need reform to discourage first-dollar coverage and encourage stop-loss protection (some plans today cover copayments and deductibles only). Ideally, benefit rationalization would reduce or eliminate the need for Medigap. Without such rationalization, Breaux proposal likely to reduce Medigap takeup, worsening Medigap selection problem and raising out-of-pocket costs for sicker beneficiaries.
BBA Extenders (primarily consist of tighter limits on growth of provider payments)	Provider payment rates are noted among "areas that need resolution."	Current hospital margins and the magnitude of the proposed payment changes suggest that they could be extended for at least 5 years. (Continuing to reduce payments beyond that might finally reduce provider participation in Medicare.) Could be used to fund some or all of the proposed prescription drug benefit.

Issue	Breaux Plan 1/26/99	Issues / Options
Changes in Medicare Eligibility		
Increase Eligibility Age	Proposes to increase to age 67 over 24 years, paralleling Social Security increase.	"Skeptical," especially in the absence of a specified buy-in plan for those approaching Medicare eligibility age.
Medicare Buy-In	Suggests buy-in plan may be possible, but offers no details.	Administration already supports a two-part buy-in: one for 62-64 year-olds, in which they pay approximately $300/month premium up front plus $200-600 annual surcharges on their premiums after age 65 (to account for the fact that higher-cost individuals are likely to sign up); and one for 55-61 year-olds who lose insurance when they lose a job, and who would pay about $400/month but have no "loan" to repay after 65. Compromise position might be a buy-in for a more limited age group (e.g., starting at 62-65 to match Social Security early eligibility and gradually increasing with NRA). Those buying in would receive no premium support, and because of adverse selection would need to pay an additional premium surcharge to avoid increasing program costs (surcharge could be limited to 62-64 year-olds, but this would reduce savings from raising eligibility age) Analysis of previous Administration proposal suggests those buying in would have expected costs around 133-150% of average.

Issue	Breaux Plan 1/26/99	Issues / Options
Part A Medical Education and Disproportionate Share Payments		
Direct Medical Education (DME)	Carve out from Medicare Part A and fund as mandatory or discretionary appropriation; would also make available to all residency programs.	Unclear. Shifting these programs to general revenues would improve Trust Fund solvency (about one year) and progressivity, and medical education payments are probably allocated to hospitals inefficiently. However, they do provide important support to teaching hospitals - which not only provide education but also treat more difficult cases, and (often) large shares of uninsured patients. Making these payments discretionary would probably lead to larger reductions over time.
Indirect Medical Education (IME)	Retain but revisit appropriate payment rate.	
Disproportionate Share (DSH)	DSH and other subsidies "should be revisited to ensure that Medicare's support is reasonable and appropriate." Possibility of carve-out noted.	Unclear. Carve-out to discretionary budget would improve Trust Fund solvency (around one year), and improves actuarial balance (by about 0.1 percent of payroll). Payments are probably allocated inefficiently, and financing through payroll tax may not be best policy. But they provide substantial funding for hospitals that treat a many uninsured and Medicaid patients, and they would be more likely to fall over time if they were discretionary.

Issue	Breaux Plan 1/26/99	Issues / Options
Addressing Trust Fund Solvency		
Additional Revenues	Suggests that financing changes should not be considered until structural reforms are in place. Republicans reluctant to add any new funding.	Medicare needs infusion of revenues, i.e. transfer of 15% of unified surplus for 15 years as proposed in SOU. Possible further steps: combine HI and SMI Trust Funds, add general revenues as needed to supplement payroll taxes – to improve progressivity and avoid issue of "insolvency"? If not, how would premium contributions be allocated to Parts A and B?
Limiting Medicare Cost Growth	Unclear how much this will be addressed. No explicit statements recently. Actuarial scoring likely to suggest no significant savings from premium support in Breaux plan: it lead to modest reduction in long-term growth rate of Medicare costs, but offsetting impact on Medicare outlays because beneficiaries choose plans with more generous benefits under premium support (traditional FFS Medicare is not a generous benefit package). Modest improvements in solvency (several years) may result from increasing eligibility age and carving out medical education and/or disproportionate share payments.	BBA extenders would have modest positive effect. Unclear how much further extension of Trust Fund solvency is a priority. Pro: Continuing rapid change of health care system suggests that reform should be revisited frequently, so that very long-term solvency is impossible to predict and should not be a high-priority goal – better to make system more rational and efficient so funds are spent wisely whatever their level. Extending Trust Fund solvency to 2020 provides a substantial window to consider whether further reforms are needed. Con: Very likely that health care costs will continue to rise, so deferring further attention to program cost growth may make it tougher to address later.

Now, the Hard Part

MEDICARE HAS LONG DEFIED ATTEMPTS TO REFORM IT. BUT A BIPARTISAN COMMISSION SHOWS SIGNS OF COALESCING BEHIND A MARKET-ORIENTED APPROACH TO KEEP THE SYSTEM AFLOAT.

BY MARILYN WERBER SERAFINI ■

The conventional wisdom is that not much of anything will get done in Washington next year, because of the new, slimmer Republican majority in Congress. But a diverse group of legislators and health care policy experts is determined to make reform of the huge Medicare system the exception, even though any attempt to change the health insurance program for the nation's elderly is certain to be politically volatile.

The 17-member National Bipartisan Commission on the Future of Medicare, created by Congress in 1997, is getting ready for the final, and most difficult, phase of its work: devising reform recommendations that can be enacted in 1999, before the 2000 presidential election takes over the political landscape. Having held hearings throughout much of this year, the commission is set to begin drafting a reform plan in early December. Under its charter, the panel has until March to make its recommendations. "There's no excuse for not acting next year," said Sen. John B. Breaux, D-La., who chairs the commission.

AP/DENIS PAQUIN

The challenge is huge:

- According to current projections, the part of Medicare that pays for hospital care will go broke in 2008 if Congress does nothing.
- Medicare hasn't kept pace with changes in the medical and insurance worlds. More than 80 percent of Medicare beneficiaries are still in the expensive fee-for-service system, which lets patients go to the physicians of their choice. Most of their kids and grandkids have moved on to more-cost-conscious managed care plans, which seek to limit health care choices.
- Benefits are an ongoing concern—in particular, the lack of coverage for prescription drugs.

Past efforts to restructure Medicare have been notably unsuccessful. After taking control of Congress in 1995, Republicans tried to revamp Medicare to extend its solvency, but Democrats successfully hammered the GOP proposals, a stance that helped them win back House seats in the 1996 elections. Several years earlier, in 1988, Congress had thought it was doing the elderly a favor by passing legislation that added a prescription drug benefit and limited recipients' out-of-pocket expenses for long hospital stays. But elderly Americans were so upset about the premium hikes needed to pay for the new benefits that Congress ended up repealing the law a year later. Representatives still well remember that angry constituents chased then-Chairman of the House Ways and Means Committee Dan Rostenkowski, D-Ill., down a Chicago street. Since then, Congress has avoided making many changes that directly affect beneficiaries, opting instead to cut payments to doctors and hospitals as a way to check the program's growing costs.

Despite this sobering history, many members of the Medicare commission appear enchanted with an idea that has the potential to transform Medicare into a market-based system, yet maintain the guarantee that the elderly will get certain benefits. It's called premium-support, and it strongly resembles the widely acclaimed system through which federal employees now get their health care—the Federal Employee Health Benefits Plan.

Robert D. Reischauer and Henry J. Aaron, both senior fellows at the Brookings Institution, put the "premium-support" name on the idea a few years ago, but it hasn't drawn much attention until now. Here's how it would work: The government would specify a minimum benefits package, though health plans could offer more services. The government would divide the country into market areas and take bids from health plans that wanted to serve Medicare beneficiaries in each area.

From those bids, the government would decide on an amount of money that it would pay in premiums for each individual in the area. The idea is that the government payment would cover most of the premium in a basic plan. Beneficiaries who opted for health plans with richer benefits would have to pay more. Each area would have government administrators to provide participants with information about the health plans, collect premiums, enroll participants and distribute payments to the plans. Once the government had paid its share of a beneficiary's premium, the health plan and the covered individual would pay for anything else.

Reischauer said he's confident that this kind of structure would save Medicare money, although he acknowledges that the Congressional Budget Office would have a hard time predicting how much. Some commissioners said they could support this approach only if recipients would receive as many benefits as they get now—plus a prescription drug benefit and perhaps a few more.

Interviews with the 17 commission members suggest general agreement that Medicare's benefits package is inadequate. Commissioners cite its lack of coverage for prescription drugs and mental health services, and its limited coverage of long-term care. Unlike most private insurance plans, Medicare does not limit the amount of money it can require a patient to spend out-of-pocket.

AP/JACK LU1

SENSITIVE TERRITORY: Commission members (below), including Illene Gordon (left) and John Breaux (right), visit a hospital. At right, the elderly protest Medicare changes proposed in 1995.

AP/ANN HEISENFELT

Concerns about Medicare's benefits package have prompted some 13 million people to purchase so-called Medigap policies from private insurers. Beneficiaries can choose from 10 standardized Medigap plans, all of which cover deductibles and co-payments, and some of which offer a prescription drug benefit. Some commissioners argue in favor of dissolving Medigap and incorporating some of its benefits into Medicare's core benefits program.

But even if the commission rallies around a set of proposals, there's no guarantee that Congress would approve the package. Commission members worry that there won't be enough pressure from the public to spur Congress to act. Complicating matters, President Clinton wants Congress to consider reforming Social Security—and it's doubtful that Congress would be able to move on both Social Security and Medicare in one year.

Breaux argues that Medicare is a more immediate problem, noting that while Social Security is slated to go broke around 2015, Medicare has only until about 2008. "Both are severe problems, but here we're talking about someone's health. We haven't gotten the attention, and while saving Social Security is important, we need to save Medicare first, then Social Security," he said.

Some are also concerned about time. The commission must report its recommendations by March, and it hasn't yet begun considering reform plans. "We haven't even come to grips with whether this is to save money or make a better program," said Rep. James A. McDermott, D-Wash. "The ones who are optimistic say you can do both. I say, 'Put your proposal on the table, and let's look at it.' I've done enough stuff to be very [wary] about people who have an easy answer."

McDermott also complained that commissioners haven't had enough time to kick around ideas. "There has to be a process by which you put a proposal out there and let us look at it, haggle over it. If this is a major public policy change—and it is—then you have to go through the process of letting people look at it and vet it."

The election was one reason why reform proposals weren't aired earlier. Several commissioners said that panel members agreed not to talk about Medicare revenue sources—always a

contentious topic—until after Nov. 3. Likely revenue options include raising Medicare's eligibility age from 65 to 67, charging wealthier people more to get Medicare benefits, instituting a co-payment for home health care services, and creating private investment accounts to help people save for their future Medicare needs. Other politically difficult questions include whether to allow uninsured individuals under age 65 to buy into Medicare and whether to encourage more of the elderly to move from fee-for-service Medicare to managed care.

Some commissioners said that achieving consensus might be easier, now that Speaker Newt Gingrich, R-Ga., is leaving the House. Gingrich appointed four members to the commission on the condition that they would not agree to new taxes. "This opens up a fresh slate, as far as I'm concerned," said Breaux. "There's less pressure to be told what to do from Gingrich. People on the commission may have some flexibility that they didn't have before."

What follows is a look at where the commission members stand as they enter this critical, decision-making stage. Members are grouped according to who appointed them. Clinton, Gingrich and Senate Majority Leader Trent Lott, R-Miss., named four members each; House Minority Leader Richard A. Gephardt, D-Mo., and Senate Minority Leader Thomas A. Daschle, D-S.D., named two members apiece. Breaux was jointly appointed.

JOHN BREAUX

Sen. John B. Breaux, D-La., is chairman of the Medicare commission and a member of the Senate Finance Committee. He was appointed chairman by President Clinton and congressional leaders. His priorities: Extend Medicare's solvency and infuse competition into the system.

Breaux has long advocated transforming Medicare into something resembling the Federal Employee Health Benefits Plan, which has been touted as the most successful and efficient health care system in the country. The Federal Employee Health Benefits Plan collects bids from health plans competing to serve federal employees, then bases premiums on those bids. It gives participants a huge choice of health plans with varying benefits and prices.


RICHARD A. BLOOM

"The idea is to come up with a defined package of benefits for recipients. We would have an outline of what they're entitled to," Breaux said, adding that he'd like to see Medicare's benefits package improved. "It's not in keeping with what we need. Prescription drugs are now as important as a hospital bed was in 1965, perhaps more so."

Breaux said he's intrigued by the idea of having young people invest in special accounts for their retirement health care needs: "It makes people more careful in what they purchase and how they purchase it." But he acknowledged that this proposal hasn't gotten much attention from other commission members. Other possible changes Breaux cited include combining Medicare's Part A (hospital coverage) and Part B (basic doctor care); and making private Medigap insurance unnecessary by improving Medicare's benefit structure.

CLINTON'S APPOINTEES

STUART ALTMAN

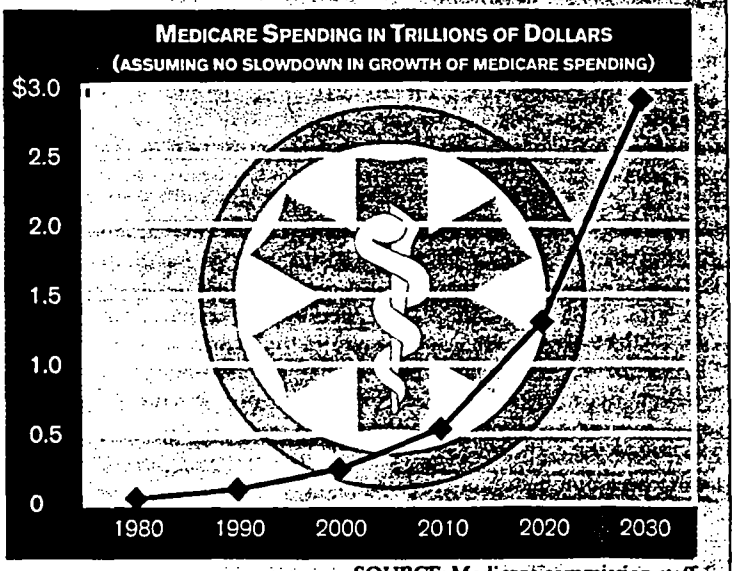
Stuart H. Altman is a professor of national health policy at Brandeis University's Florence Heller Graduate School and a former chairman of the Prospective Payment Assessment Commission, a government panel that advised Congress on Medicare payment policies. His priorities: Preserve Medicare as a government program and add a prescription drug benefit.

His concern is that Medicare leaves millions of elderly Americans unable to afford prescription drugs and related out-of-pocket expenses. The most comprehensive supplemental insurance comes in the form of retiree health plans, but

TODAY'S MEDICARE

- 39 million seniors and disabled people have Medicare.
- 17 percent of beneficiaries are in health maintenance organizations.
- Medicare Part A covers hospital stays. Part B covers basic doctor services.
- Medicare Part A is projected to go broke in 2008.
- Under current projections, Medicare spending could account for 8 percent of GDP by 2030 (up from 2 percent in 1995), and 37 per cent of the federal budget (up from 11 percent in 1995).
- Most beneficiaries have supplemental insurance to cover co-payments and deductibles (35 percent have Medigap, 35 percent have retiree plans, 15 percent have Medicaid). About half have a prescription drug benefit through other insurance.

SOURCES: Medicare commission staff, Medicare Payment Advisory Commission, Health Care Financing Administration



SOURCE: Medicare commission staff

Altman noted with alarm that employers are beginning to stop providing that benefit. Meanwhile, Medigap policies are expensive and their benefits are limited.

Nearly half of the elderly don't have prescription drug coverage. "I cannot support any long-term plan that doesn't cover prescription drugs in some way," he said, although he said he realized it's an expensive benefit—by some estimates, covering all Medicare recipients would cost $40 billion a year.

COURTESY OF BRANDEIS UNIVERSITY

Altman said one option is to keep the existing Medicare structure and have wealthier people pay more. But he said he's open to different ways of adding new benefits, including through a so-called premium-support system, "provided it's adequate, and the benefits there are clear and that we have a fair system that doesn't adversely affect low-income elderly." However, he added, "I'm not signing up yet. I want to be assured that the beneficiaries get decent protection."

Laura D'Andrea Tyson

Laura D'Andrea Tyson is the dean of the Haas School of Business at the University of California (Berkeley), and a former national economic adviser. Her priorities: Add flexibility so Medicare can change with the times, and establish regular reviews to assess the program's performance.

Tyson warned against making radical changes based on long-range economic forecasts. (Congress has asked the commission to propose changes that would keep Medicare solvent through 2030.) Part of the problem, she said, is that there's no way to know whether tomorrow's elderly population will act like today's, mostly because the newcomers will have had more experience with managed care. That's why she favors the regular reviews: "It's a mistake to leave the American people with the view, 'Here's the problem, here's the solution,' " she said.

RICHARD A. BLOOM

Tyson also emphasized the need to make Medicare more efficient, regardless of how much money is saved. She cited the proposal of having health plans submit competitive bids to insure the elderly. "Everyone thinks it's more efficient, but I don't know how much it saves."

Significant improvements in the program, though, hinge on incorporating Medigap benefits into Medicare so that people who can't afford Medigap have more protection. "It's supposed to be a program that gives beneficiaries help based on their status as elderly, not on their income," she said.

Bruce Vladeck

Bruce C. Vladeck is a professor of health policy and geriatrics at Mt. Sinai School of Medicine, in New York City, and a former administrator of the Health Care Financing Administration, which oversees Medicare. His priority: Resist drastic changes.

Vladeck says he can't support overhauling the program solely because of troubling long-term economic projections. "We shouldn't exceed what we know." Forecasts of more than 10 years, he said, "fall off into meaninglessness."

Yet Vladeck worries that commissioners with ideological agendas may be able to use fear that the program will go bankrupt in 2008 to successfully sell radical restructuring. "Is there a long-term Medicare problem?" said Vladeck. "We just don't know how big it is and whether it will fix itself."

COURTESY OF BRUCE VLADECK

Vladeck says he is particularly concerned about the 15 percent to 20 percent of Medicare beneficiaries who can't afford private Medigap insurance yet aren't poor enough to qualify for Medicaid, the federal-state health care program for the poor. Any Medicare savings should be plowed into prescription drug and mental health benefits, Vladeck maintains. A way of saving money that he would find acceptable: Establish a target growth rate for the program, and institute a self-enforcing cost-control mechanism that would kick in every three to five years.

Anthony Watson

Anthony L. Watson is chief executive officer of the HIP Health Plans. His priorities: Resist radical changes and simplify the program.

"It's clear to me that you can't try and project [Medicare's solvency needs] out to 2030," he said. "It's impossible to do that with any precision. We should go for the next 10 years." Watson said he might be able to back a premium-support proposal, depending on its structure. "The devil's in the details," he said, adding that he's afraid that volatility in the health care sector could cause chaos.

COURTESY HIP HEALTH PLANS

Next year, for instance, dozens of health maintenance organizations will stop serving Medicare recipients, leaving about 400,000 elderly to find other care. "HMOs are leaving the markets now. How do you keep that from happening?" Watson asked. The existing Medicare system, meanwhile, needs simplification, he said. There's some rationale, he said, for combining Medicare's Part A (hospital coverage) and Part B (basic doctor care).

Gingrich's Appointees

Michael Bilirakis

Rep. Michael Bilirakis, R-Fla., is the chairman of the House Commerce Committee's Health and the Environment Subcommittee. His priorities: Extend Medicare's solvency at least through 2030 and achieve tort reform.

It's very possible to ensure Medicare's financial health through 2030, "or even further," said Bilirakis, adding that tort reform is "the best way to save money." He says that if Congress imposes limits on medical malpractice awards, the savings will ripple through the health care system.

What Bilirakis doesn't want to do is cut benefits to

patients or reimbursements to doctors and hospitals. In fact, he wants to create a benefit for prescription drugs. He said that Medicare also needs to improve its long-term-care benefit. Congress could accomplish some of this by incorporating Medigap benefits into the main Medicare program or by changing Medicare so that beneficiaries pay more of their deductibles and co-payments, he said.

Representing a constituency of whom nearly 25 percent are over the age of 65, Bilirakis said he feels strongly that the commission needs to tackle some nuts-and-bolts Medicare issues. He favors decreasing the paperwork and simplifying the procedures so that doctors need not get permission from nondoctors before treating patients.

Colleen Conway-Welch

Colleen Conway-Welch is the dean of the Vanderbilt University School of Nursing and was named by Gingrich on July 24 to replace Rep. Greg Ganske, R-Iowa, who left the commission after a dispute with the speaker over managed care reform. Conway-Welch's priorities: Add a prescription drug benefit and ensure preventive care and more competition in the Medicare system.

Conway-Welch says competition may be the only way to provide more benefits in an affordable way. She likes the approach of the Federal Employee Health Benefits Plan. "It has a number of plans available, from Volkswagen to Mercedes, and there's the opportunity to accept a plan that fits a person's particular needs," she said.

Her concern is that the commission has not decided between two ways of structuring Medicare: Should the government cap the amount of money it will spend on a beneficiary over a certain period of time, or should it define the benefits it will cover, no matter what the cost? "We are obviously struggling with the issue of defined benefits vs. defined contribution," said Conway-Welch.

She is interested in Medicare as a woman's issue and in emphasizing preventive care. "Many older women don't have Pap smears or gynecological exams. Many have significant osteoporosis. We need to step back and look at the whole spectrum of care."

Samuel Howard

Samuel H. Howard is chief executive officer of Phoenix HealthCare Corp., in Nashville, Tenn. His priorities: Ensure Medicare's long-term solvency and provide more health plan choices.

Ensuring the program's financial health through 2020 is absolutely doable, Howard said. "The fact that we're still living with the [single] benefit plan set up in 1965 is archaic," he said. Medicare needs to evolve from its 1965 focus on acute (hospital) care to a focus on chronic (long-term regular) care, Howard said, adding, however, that there is no quick fix.

He said he wants Medicare to become more adaptable by becoming more sensitive to the marketplace. "Benefits are going to change. Technology is going to change. The market is sensitive to that change," he said. Medicare, he added, is not.

Howard said it would be "worth exploring" the model of the Federal Employee Health Benefits Plan for ways of creating a competitive structure. For starters, he advocates removing the upcoming Medicare+Choice program from the oversight of the Health Care Financing Administration. Medicare+Choice, which will be launched next year, is designed to give the elderly some of the same health plan choices available to the under-65 population. It will include all of Medicare's managed care plans and other alternatives to traditional fee-for-service. Howard and other critics of the agency arrangement have suggested that Medicare's managed care options should not be run by the same agency (HCFA) that runs Medicare's fee-for-service program.

William Thomas

Rep. William M. Thomas, R-Calif., is the administrative chairman of the Medicare commission and the chairman of the House Ways and Means Health Subcommittee. His priorities: Extend Medicare's solvency and make the program more market-oriented.

"We have to rethink the entire structure of Medicare and not continue the same old statutory responses," he said. Thomas led the push to create Medicare+Choice as part of the 1997 Balanced Budget Act. Thus far, although the elderly can choose health maintenance organizations instead of fee-for-service plans, Medicare has not offered preferred provider organizations, medical savings accounts or other options.

Thomas wants to add more competition to the Medicare program, perhaps by using the federal employees' plan as a model. Thomas called Medicare's current structure inefficient, particularly its spawning of Medigap supplemental insurance policies. A recent study by the Medicare Payment Advisory Commission found that elderly Americans with Medigap tend to overuse basic Medicare services, because Medigap allows them to pay fewer out-of-pocket costs.

Thomas also said that certain essential services—such as a prescription drug benefit—could be incorporated into Medicare if beneficiaries paid more in deductibles and co-payments. He also said he supports limiting the amounts beneficiaries must pay for catastrophic illnesses.

Lott's Appointees

Bill Frist

Sen. Bill Frist, R-Tenn., is chairman of the Senate Labor and Human Resources Public Health and Safety Subcom-

mittee. His priorities: Rethink graduate medical education payments, extend Medicare's solvency and make Medicare more market-oriented.

Adding competition will be a key to the program's long-term financial health, Frist said. He favors using the federal workers' program as a model. Though premium-support should be a component of any recommendations the commission makes, he says that Medicare's traditional fee-for-service option should remain a part of the system.

"I don't think we know enough to go to full premium-support," he said. "When you plug in the question about security *for* seniors, I don't know that [premium-support] will be the final answer." He said he would not want to see a "defined-contribution" system, under which Medicare limited the amount of money it would pay in a given time for each beneficiary.

Frist, a heart transplant surgeon, is especially interested in the financing of graduate medical education through Medicare. He said the commission needs to decide whether educating physicians should be a societal goal that deserves the federal government's financial backing.

Frist also said the commission needs to consider the priorities of this country's elderly—such as security, simplicity and more choices of health plans. He advocates adding a prescription drug benefit and perhaps a benefit for mental health care as well.

Illene Gordon

Illene Gordon is a staff assistant in Senate Majority Leader Trent Lott's state office in Jackson, Miss. Her priorities: Add a prescription drug benefit, improve the long-term care benefit and require young people to save for their later health care needs.

Gordon, 71, gets an earful of complaints every day in Lott's Jackson office, where her job is to help constituents with Medicare problems. (Some commissioners had been concerned that she would act strictly as a mouthpiece for Lott, but now they regard her more as a spokeswoman *for* the elderly).

"One of my priorities is prescription drugs," she said. "We have a lot of people, couples who are both disabled, maybe in their 80s, living on less than $800, or $600, a month, but who can't qualify for Medicaid. It's sometimes a choice between prescription drugs and food. We hear a lot of that." She added that constituents also call because they need long-term care, which Medicare covers only on a limited basis; and they have too many financial assets to qualify for Medicaid, which would cover most of it.

But Gordon acknowledged the difficulty of adding benefits and keeping Medicare from going broke. She says she's open to the concept of getting the under-65 population to invest in private savings for later medical needs.

Phil Gramm

Sen. Phil Gramm, R-Texas, is chairman of the Senate Finance Health Care Subcommittee and heads the Senate GOP Healthcare Task Force. His priorities: Extend Medicare's solvency and get young Americans to save for late-in-life medical costs.

"What's most important is our mandate of trying to save Medicare," he said. In his view, that means promoting efficiency and controlling costs. Gramm calls the current cost-sharing system irrational. For example, he says it's illogical for Medicare to require no co-payment from beneficiaries for their first 90 days in a hospital and big co-payments for longer stays. "It induces people to buy supplemental insurance that's very expensive and ineffective," he said. "We have a collage of co-payments and deductibles, with no rationale."

Gramm favors requiring the elderly to pay more in deductibles and co-payments and abolishing limits on how much Medicare will pay for an extensive hospital stay; such a limit now "ruins people financially if they get very sick."

Making Medicare more like the Federal Employee Health Benefits Plan is a step in the right direction, he said. He says he likes the market approach of that program, which limits the money the federal government pays for each person.

Gramm has written a proposal to require young people to invest privately to save for their medical expenses.

Deborah Steelman

Deborah Steelman, an attorney in private practice, headed a Social Security and Medicare council during the Bush administration. Her priority: Make Medicare more like the working population's market-oriented programs.

Her main concern is that Medicare doesn't allow patients to fully insure themselves against risk, "and that's wrong," she said. In the private sector, she continued, people are "not faced with the prospect of a cap, after which the insurance company won't pay. They're not faced with the problem of, 'I hope I get sick in a way that I don't need pharmaceutical therapy.' My main concern is to try to, in a fiscally solvent and fair way, *to correct that phenomenon.*"

The challenge, she said, will be to rework the connections between Medicare, Medigap and Medicaid so that they "make sense." One priority: Combine Medicare's Part A and Part B.

Steelman says she's also committed to making sure Medicare is self-sustaining, so that she and other baby boomers are not "forced to demand that the population behind us pays for us." That could mean requiring that beneficiaries pay a greater portion of their anticipated Medicare expenses in advance or that wealthier elderly people pay more. She is concerned that people with Medigap cost Medicare too much, because they are more prone to overuse basic doctor services.

Gephardt's Appointees

James McDermott

Rep. James A. McDermott, D-Wash., is a member of the House Ways and Means Committee. His priorities: Preserve the current system, add a drug benefit, ensure a continuum of care and improve coverage for long-term care.

There's a split on the commission about how to define what's wrong with Medicare, he said: "If you say it's that we're spending too much money, it sends you off in one direction. If you say [the program] was designed 30 years ago and needs to be modernized, it sends you off in another direction. I'm in the second category." Commissioners who say you can both modernize and cut costs are overly optimistic, he said.

To move forward, there must be an acknowledgment that what Congress tried to do in the 1997 Balanced Budget Act—to "cram everyone into [HMOs]—is not going to work."

McDermott, who wants to help low-income people cover their out-of-pocket costs, also said any revised plan has to include a prescription drug benefit. Like many of his colleagues, McDermott wants to revamp Medigap, perhaps by incorporating it into Medicare. But he criticized proposals that would keep the elderly from buying Medigap plans to cover all out-of-pocket costs.

Senior citizens, he said, don't "sit around and say, 'Well, gee, I haven't seen my doctor in a while, I think I'll go in and see him.' We go [to the doctor] when we're scared."

John Dingell

Rep. John D. Dingell, D-Mich., is the ranking member of the House Commerce Committee. His priorities: Preserve the existing program, add a pharmaceutical benefit and head off the proposed deep cuts and limits on government payments.

Dingell, who voted in 1965 to create Medicare, says he is determined to preserve the program in its current form, while adding a prescription drug benefit. "We said at the beginning that this was a needed level of benefits," he said. "I'm not for dismantling the system. I'm not for forcing people into [HMOs]. I'm not for gutting benefits or the program."

Dingell said he will try to scuttle attempts to set a ceiling on the amount the government would pay on behalf of an individual. He said he's willing, though, to discuss moving more toward a system like the federal employees'. He wants to help people who make too much money to qualify for Medicaid, but not enough to cover their share of their Medicare costs. "I'm sure not going to pile any more miseries on the ones at the bottom of the totem pole," he said.

Daschle's Appointees

Robert Kerrey

Sen. Robert Kerrey, D-Neb., a member of the Senate Finance Committee, was co-chairman in 1994 of a congressional commission on entitlement reforms. His priority: Achieve long-term solvency by making bold changes. ✓

Instead of fixing the current Medicare system, Kerrey would like to see new approaches. But he's not optimistic. "We still don't have a mandate from the electorate," he said. "The problem with Medicare is that it's not that well-understood. . . . Any problem that isn't imminent is not a political problem with the electorate."

Kerrey said his main objective is to stabilize Medicare costs so they don't consume an ever-growing share of the federal budget. "There are those who say you can't forecast out 25 years, that you can't know where this trend is going," he said. "That argument is typically authored by someone who doesn't want to make changes in the program. By next year, Congress will be looking as far ahead as 2010 when it writes its federal budget, and the extent of the problem will become more clear. We'll be able to see the beginning of the baby boom retirement age. Right now, boomers don't exist [in Medicare terms]. If you don't see it in the budget window, it's not real."

In the Senate Finance Committee last year, Kerrey advocated controversial proposals to cut Medicare's costs, including increasing the eligibility age from 65 to 67, starting to require a co-payment for home health care services and charging wealthier people more for Medicare.

Jay Rockefeller

Sen. John D. "Jay" Rockefeller IV, D-W.Va., a member of the Senate Finance Committee, was chairman of a commission on long-term health care in 1989. His priorities: Preserve the current system and fight attempts to impose limits on how much Medicare will pay for any one person.

"That is basically saying to someone with diabetes or a whole range of diseases, 'Here is $5,000, and good luck,' " he said. "If you have diabetes, it costs $12,000 a year."

A premium-support system modeled after the federal workers' plan might be worth examining, he said, but he worries that limits may be imposed on spending for an individual.

"I want to make sure that we really know what we're doing. Sometimes commissions want to strike out with a brand-new idea, without knowing what the effects are," he said. "There are discussions about [the Federal Employee Health Benefits Plan], but there's little written as back-up for it."

What does he favor, then? "I'm about solvency, plus making sure seniors get the benefits they need, the most important of which is prescription drugs," he said. But Rockefeller added that he's worried about overly ambitious plans for rescuing Medicare. "It's hard to predict, because of how fast things are changing," he said. "It would be great if we could do something [that would work] through 2015. Medicare's going to go through a lot of changes. To posture as to what they're going to be, much less legislate it, is pushing it." ■

JOHN BREAUX
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MEMORANDUM

To: Vice President Gore
From: Senator Breaux
Date: November 19, 1998

As a follow-up to our discussion last week, I want to reinforce my point that we need to talk about restoring solvency to Social Security in conjunction with a discussion about restoring solvency to Medicare. There are several reasons why I think this is important.

1. The financial problems facing Medicare are even more grave than those facing Social Security. Unlike Social Security which continues to take in more revenue through the payroll tax than it pays out in Social Security benefits, Medicare is spending more on Part A benefits than it takes in through the payroll tax and has been since 1995. Medicare's HI Trust Fund will also be insolvent at a much earlier date than the Social Security Trust Fund--2008 as opposed to 2029.

2. Medicare has a significant impact on the income security of the elderly population. Since Medicare was enacted, the poverty rate among the elderly has declined from 29% to 10.5%. However, the elderly are spending an increasing amount of their retirement income on out-of-pocket health care costs.

3. In 1997, Medicare's share of the federal budget was 12% and Social Security's share was 21%. The projections for 2030 show that Social Security and Medicare will consume half of the federal budget in almost equal shares--26% and 24% respectively.

In the debate over the 1997 Balanced Budget Act, the Senate, by large, bipartisan margins, supported politically difficult changes to Medicare that would have extended the solvency of the trust fund by a few years. While these changes would not have put Medicare on firm financial footing or conformed Medicare's benefit design to the modern notions of comprehensive health care coverage, they were still too controversial to become enacted into law. Hopefully we will refrain from politicizing the issue of Medicare, since 2008 is less than a decade away and the consequences of inaction are severe.

The National Bipartisan Commission on the Future of Medicare was created because the Administration and Congress recognized the need to develop a bipartisan, comprehensive solution to restore the long-term solvency of the program. The Commission is required by statute to make recommendations in several areas including Medicare's eligibility age, Graduate Medical Education, and the health needs of the chronically ill. Our report must be submitted to Congress and the President by March 1, 1999. The Commission has held more than thirty hearings at both the task force and full Commission level to seek input from providers, beneficiaries and analysts and to gather information regarding the scope of the problem facing Medicare. We are considering a wide range of options and I am committed to finding a "center out" solution that meets the Commission's statutory objectives.

It is my hope that the Commission can make bold recommendations, bolder than what may be possible for Congress to enact and the Administration to support. These recommendations should ensure that Medicare is able to provide the current benefits package to future beneficiaries before new benefits are considered but we will also explore the types of reforms that would make expanded coverage possible. We can't do this unless we have bipartisan support, including support from the White House appointees who are critical to this process.

The next meeting of the Commission is December 2nd and 3rd. We will be discussing at length various reform options. I will touch base with you again as it becomes clearer what recommendations might be included in the final report. I look forward to working with you and the President as we move forward.

Date:_____

FAX

Health Division

Office of Management and Budget
Executive Office of the President
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DRAFT: NEC MEDICARE COMMISSION PRINCIPALS' MEETING

OEOB Room 180; 3:15pm
February 22, 1999

AGENDA

I. PREMIUM SUPPORT (15 minutes)

- **Policy**
- **Politics**

II. OPTIONS (45 minutes)

- **Guidance for Upcoming Commission Meetings**
- **Response to Commission Vote**

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POLICY PROS AND CONS OF PREMIUM SUPPORT

PROS

- **Would likely reduce Medicare costs through competition.** Premium support encourages beneficiaries to choose lower cost health plans by giving them a financial incentive to do so. Depending on how premium support is structured, efficient plans can attract beneficiaries by offering lower premiums or additional benefits. As beneficiaries move to lower-cost plans, the national average Medicare spending is reduced (or doesn't grow as fast as it would have), thus reducing Federal Medicare costs over time.

- **Better aligns Medicare with private health insurance.** Today, Congress and the President must make explicit changes to Medicare reimbursement levels to control program costs. While over time the growth in Medicare has roughly matched private health insurance growth, cost control is cumbersome and subject to significant political constraints. Under premium support, Medicare spending is more dependent on the ability of private plans to achieve efficiency, which should more closely align the growth of future government Medicare spending with the overall level of efficiency achieved by private health insurers.

- **Gives beneficiaries more choices.** Today, beneficiaries enroll in managed care plans because, in some areas, those plans can offer extra, free benefits. Under this proposal, beneficiaries can lower their Medicare premiums by enrolling in low-cost plans and, under some proposals, also get some extra benefits. Premium support also has the potential to attract more private plans to participate in Medicare or extend their market area, since they would have new flexibility to use financial incentives to attract beneficiaries.

CONS

- **Premium for traditional Medicare will likely be higher than private plan options.** Since the government's contribution to the traditional Medicare would be based on the premium support program, the Medicare fee-for-service premium can be expected to be higher than that of private plans -- especially if it is not allowed to use the same management tools as private plans. This could put people who do not want to enroll in private plans or who don't have the option (e.g., in rural areas) at a financial disadvantage. It could also create confusion and anxiety for beneficiaries -- and may not be worth it if the savings from premium support are small.

- **Could reduce extra benefits that current Medicare managed care enrollees receive.** Currently, Medicare managed care plans compete for enrollment by offering beneficiaries additional benefits such as lower cost sharing, preventive care, and outpatient prescription drugs. Under premium support, a greater share of the efficiency savings accrue to the government, reducing the amount that can be provided as additional benefits.

- **Significant regulation would be required to avoid two-tiered Medicare.** To promote competition based on price and quality -- rather enrollment of the healthiest beneficiaries -- significant new rules and oversight would be needed. Without such rules, or because of imperfect implementation, premium support could have the unintended effects of creating higher premiums for people who are sick and low-income.

POLITICAL PROS AND CONS OF SUPPORTING PREMIUM SUPPORT

PROS

- Elite validation would enhance credibility and increase likelihood of bipartisan agreement on Medicare -- and Social Security.
- Would significantly increase the likelihood of a drug benefit for all beneficiaries and new purchasing tools for the traditional program.
- Drugs and the dedication of the surplus in return for premium support may be a good trade.
- Defining acceptable premium support at the beginning of the debate will give us more credibility in opposing at the end of Congress passes a flawed version.

CONS

- Will alienate Democrats base, particularly in the House.
- Risk of higher premiums and elderly dissatisfaction is too high relative to any potential positives.
- More difficult to oppose premium support at the end of the process -- particularly if included in a broader reconciliation.

OPTIONS FOR FEBRUARY 23, 24 MEETINGS

I. REJECT COMMISSION PLAN; CONCLUDE THAT THERE IS NOT ENOUGH TRUST OR TIME TO WORK OUT DETAILED COMPROMISE; REITERATE PRINCIPLES FOR REFORM

II. CRITIQUE COMMISSION PLAN AND LACK OF DETAILS; REITERATE SPECIFIC IMPROVEMENTS NECESSARY TO SUPPORT; SUGGEST WILLINGNESS TO CONTINUE TO WORK FOR COMPROMISE AND OPENNESS TO EXTENSION

III. REJECT COMMISSION PLAN AND PROCESS, SUGGEST THAT WE'LL OFFER AN ALTERNATIVE WITH PREMIUM SUPPORT

IV. REJECT COMMISSION PLAN, SUGGEST THAT WE'LL OFFER AN ALTERNATIVE LOWEST COMMON DENOMINATOR PLUS PRINCIPLES FOR VIABLE PREMIUM SUPPORT

DRAFT BACKGROUND: PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES

NEED AND USE AMONG MEDICARE BENEFICIARIES

- Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. (Davis et al., 1999).

- Medicare beneficiaries with coverage for drugs used, on average, 20.3 prescriptions per year, compared to 15.3 per year for beneficiaries without coverage. (Davis et al., 1999)

- 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 Medicaid drug coverage was limited. (Soumerai et al., 1987)

- Another study found that elderly, ill Medicare beneficiaries whose Medicaid coverage was limited were twice as likely to enter nursing homes. (Soumerai et al., 1991)

- The odds that Medicare beneficiaries use drugs to treat their health problems increases by 60 percent if they have insurance. (Stuart & Grana, 1998)

SPENDING

- In the past 10 year, 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. (HCFA, 1998)

- Although the elderly comprise 12 percent of the population, they account for over one-third of all prescription drug spending. (Mueller, Schur & O'Connell, 1997)

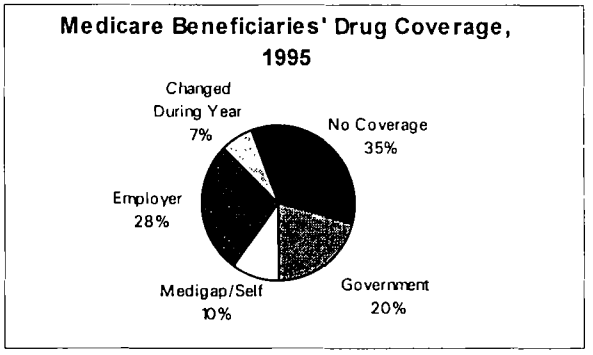
- The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication. (Mueller, Schur & O'Connell, 1997)

- Spending on prescription drugs represents one-third of Medicare fee-for-service beneficiaries' out-of-pocket spending (excluding premiums payments). (AARP, 1998)

- About half of Medicare beneficiaries have prescription drug spending of more than $500 per year; over one in ten have more than $2,000. (HCFA Office of the Actuary, 1999)

INSURANCE COVERAGE

- **Only 38 percent of Medicare beneficiaries have private drug coverage.** Employer-based, retiree coverage is the largest source of private coverage, but recent studies show a dramatic decline in this coverage. About 10 percent of beneficiaries have Medigap or other private sources of coverage. Similarly, as the cost of Medigap insurance climbs, the proportion of beneficiaries who can afford it has been declining. (Davis et al, 1999)



- **Retiree health insurance**: The major source of drug coverage for the elderly -- employer sponsored retiree insurance -- is eroding. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent (from 40 to 31 percent). (Mercer/Foster Higgins, 1997).

- **Medigap**: 3 of the 10 standard Medigap plans offer prescription drugs. Their benefits includes: a $250 deductible; 50 percent coinsurance; and a cap of $1,250 or $3,000.

  Medigap premiums in general have been rising rapidly. One study of Medigap in 3 states found that premiums for the two most popular plans rose by 12 and 20 percent between 1995 and 1996. (Eppig & Chulis, 1997)

  Medigap coverage has declined from about 40 percent in 1984-87 to 30 percent in 1996. (Medicare Commission staff analysis)

  Medigap premiums range from $402 to $7,196, depending on the state and type of coverage. The median premium for a 65-year old choosing a plan with prescription drug coverage (Medigap Plan H) to one with virtually identical benefits except for drugs (Medigap Plan D) is well over $1,000 or more than twice as costly ($2,073 v 913 in 1998). (Medicare Commission staff analysis). According to experts, virtually all Medigap drug coverage plans are underwritten, meaning that the premiums that they charge are based on the person's health.

- **Medicare managed care**: Typical Medicare managed care plans have no deductibles and relatively low copayments, but caps on the benefit:

  - 40 percent of enrollees are in plans with unlimited benefits
  - 18 percent of enrollees are in plans with limits greater than $1,000
  - 17 percent of enrollees are in plans with a limit at $1,000
  - 24 percent of enrollees are in plans with limits less than $1,000

  [Note: these data are for 1998; expectations are that for 1999, the proportion of beneficiaries in plans with caps and deductibles will rise significantly; unpublished HCFA analysis]

BENEFICIARIES WITHOUT ANY INSURANCE COVERAGE

- **Not just a problem for low-income beneficiaries**: Over 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty.

- **Beneficiaries without drug coverage are not much healthier than those with coverage**: Although some argue that beneficiaries without coverage may not need it, 26 percent of beneficiaries without coverage report fair to poor health, compared to 29 percent of beneficiaries with drug coverage. 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**: The proportion of beneficiaries without drug coverage rises with age:

  - 38 percent of people ages 80 to 84
  - 41 percent of people ages 85 or older

- **Nearly half of rural beneficiaries have no insurance coverage for drugs**: 46 percent of rural beneficiaries do not have drug coverage

Source: Unpublished analysis of the 1995 Medicare Current Beneficiary Survey

SPENDING BY BENEFICIARIES WITHOUT DRUG COVERAGE

- Even after controlling for health status and income, elderly people with private insurance for drugs had half the financial burden for drugs as those without coverage. One percent of elderly households spend at least 25 percent of their household incomes on drugs. Rural elderly have costs that are 35 percent hgiher than urban elderly, and women have, on average, costs that are 20 percent higher than men, primarily because many are widowed and lower income. (Rogowski et al., 1997)

- A recent study found that the average older American without insurance coverage for drugs pays twice as much as large insurers or HMOs. (Committee on Government Reform and Oversight, 1998)

- A 1993 survey found that 13 percent of elderly Americans reported having to choose between buying food and buying medicine. (Families USA, 1995)

SOURCES

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UNITED STATES SENATE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
WASHINGTON, DC 20510-6300

DATE: March 3, 1999

TO: Chris Jennings

FAX NUMBER: 456-5557

FROM: David Nexon
(202) 224-7675 phone
(202) 224-3533 fax

NUMBER OF PAGES: 2 (including cover)

MESSAGE:

This is what we've been saying to Altman. Do you have any comments/suggestions?

If you have trouble receiving this fax, please call (202) 224-7675

TALKING POINTS

--I am disappointed by your offer to Breaux and Thomas.

--You have given them cover for some thoroughly bad Republican ideas: a premium support program that could force the most vulnerable beneficiaries into HMOs and a program to raise the eligibility age that could dramatically increase the number of the uninsured. As I understand your paper, you have not insisted that all GME payments be maintained as entitlements under Medicare. And I am not clear that you have insisted on the President's plan to put 15% of the surplus into Medicaid as a precondition before considering further cuts. I am glad that you are calling for a good drug benefit, but I am concerned that making it a separately purchased benefit will leave too many seniors out and promote adverse selection.

--What is the impact of the program of the total program on beneficiaries? How much more are they going to have to pay in premiums and cost-sharing under best case and worse case scenarios? How many more seniors will become uninsured if you raise the eligibility age, even with a low-income subsidy? What is going to happen in high cost and low cost geographic areas? How would GME and DSH funds be distributed if you pull them out of patient care? What's the impact on solvency of all these changes. I hope you won't even consider putting your name to something without solid estimates on each of these points for the total package.

--I understand your desire to be a bi-partisan contributer to the work of the Commission, but you and Laura have basically left the other Democrats on the Commission in the lurch by offering a separate deal. That's not the way to get where we want to go on Medicare, and it's not the way to treat people who have spent so much effort in protecting the program against the Republican assault of the last few years.

--I hope you will not agree to a separate deal with Breaux and Thomas, that you will stiffen your terms for any compromise, and that you will insist on using the surplus first as the precondition for any other changes to the program.

--I respect your commitment to the program and your insight into the policy issues, but this is one time where I really believe you have done the wrong thing--and I hope you will reconsider.

LEVEL 1 - 5 OF 5 STORIES

SHOW: TALK OF THE NATION (2:00 PM ET)

March 1, 1999, Monday

LENGTH: 7117 words

HEADLINE: DR. THOMAS BODENHEIMER, DIANE ROWLAND AND ROBERT REISCHAUER DISCUSS THE PROPOSED CHANGES IN MEDICARE

BODY:
(Technical Difficulties)

SUAREZ: He's a senior fellow in the economic studies program at the Brookings Institution and the chair of the National Academy of Social Insurances project, restructuring Medicare for the long term. Good to have you back.

Mr. ROBERT REISCHAUER: Good to be with you.

SUAREZ: Our number in Washington, (800) 989-8255. That's (800) 989-TALK. And, Diane Rowland, the Kaiser Survey showed that while people are not really sure what's in Medicaid, not exactly how it gets paid for, not exactly sure what their rights are and benefits are under the program, they do support it, which is not really contradictory, I guess.

Professor DIANE ROWLAND: It isn't. Medicare is, in fact, one of our most popular health programs. It usually ranks much higher on people's opinion than our private insurance options. People know that Medicare is there when people retire. They like and value the program. But they understand it has some deficiencies and gaps, which is part of what we'll be talking about today.

SUAREZ: What are some of the big suggestions that either win the approval or win the scorn of the people that you surveyed?

Prof. ROWLAND: Well, certainly one of the most important omissions from Medicare's current benefit package is the coverage of prescription drugs. As we've evolved our way to (technical difficulties) medical care since Medicare was enacted in 1965, prescription drugs have become a central part of the

treatment options that any physician can offer. Yet today, about a third of the beneficiaries on Medicare have no coverage for prescription drugs, and others have to pay a substantial amount on their own to supplement the coverage that they have. So a big issue in this debate is will we cover prescription drugs and add them into the Medicare benefit package, and how will we cover the cost of doing that?

SUAREZ: Well, if I remember my history of the program correctly, one of the reasons why they were left out at the beginning is that prescription drugs were pretty cheap, and some people envisioned a nightmare scenario of trying to fill 10 million or 20 million claims for $ 2 or $ 3 apiece, and they at that time thought they were wisely leaving it out. Now that drugs--a drug regimen to treat a chronic condition can cost you a couple of grand a year, it looks like something that's much more dire.

Prof. ROWLAND: Right. And now we've shifted care, really, from an intensive, hospital-based system in 1965 to doing much more on an out-patient basis, so we try to keep people at home, and we try to minimize the cost of their care by using drugs to supplement it. So that's one key improvement in the program.

Second, people talk about the need for long-term care coverage, which currently isn't available, really, through the Medicare program, yet people face huge bills for nursing home care that would help to be covered under the Medicare program. But on the other side, people are really looking at the fiscal issues, and how we can protect Medicare's solvency in the future, how can we sustain the cost of a growing program with an aging population, and that's where you get some of the other proposals that are on the table, such as the Breaux proposal for premium support, a new way of adding to the competitiveness of the Medicare program, and helping to give people assistance to go out and shop for insurance coverage instead of getting one-stop shopping through the Medicare program.

Another proposal to add to the age of Medicare so that instead of getting benefits at age 65, you might not get them until age 67. So we're looking at a broad mix of improvements to Medicare and reductions. As you might suspect, the public is far more supportive of those options that expand coverage than of those options that would reduce or cut back on coverage.

SUAREZ: Well, Thomas Bodenheimer, does that jibe with what you know about people's preferences, and how does it line up with what you've come up with in rebuilding Medicare for the 21st century?

Dr. THOMAS BODENHEIMER: As you know the Medicare Commission under Senator Breaux, the majority of the commission now favors a type of voucher system that it calls premium support. And under this plan, 40 million elderly and disabled Medicare beneficiaries would lose their red, white and blue Medicare cards and instead would receive a voucher that pays most of the cost of an insurance plan, so that Medicare would be turned into a marketplace of competing private health insurance plans, and our feeling is in the national campaign to protect, improve and expand Medicare, that this is a plan with serious negative effects, and I'll give three of them. It will fail to solve the financial problems of Medicare, which has to be done. It will shift health-care costs onto elderly and disabled people, and it's wasteful of taxpayers' dollars. And I could speak a little

more, if you want, about why I don't think this plan will save Medicare money.

SUAREZ: Yeah, let's talk about that, because I think part of the rationale is that big insurers would be competing in price and program to bring on--sign on millions of new beneficiaries. Why wouldn't it save the program money?

Dr. BODENHEIMER: Well, the main work of the commission really is to solve Medicare's financial problems so that Medicare will really be there when millions of younger Americans reach retirement age. The premium support plan may not save any money for Medicare, really relies on competition among private health insurance plans to reduce costs, and that is an assumption without a lot of good evidence to support it.

Let me just give one example. Premium support plan is modeled on the federal employees' health benefits program. If you look at the federal employees' program, since 1995, its costs have been rising faster and faster each year. And compare that to the public Medicare program we now have. Its costs, since 1995, have been going up slower and slower each year, so that in 1998, the private federal employees' program average premiums went up by over 10 percent over the previous year. In the same year, the public Medicare expenditures increased by only 1.5 percent, so this premium support program would abandon the existing Medicare program, whose rate of inflation is slowing, and would substitute a private marketplace whose rate of inflation is increasing.

SUAREZ: Well, it sounds like it's only a matter of time till people start clamoring to put all those FEHBP recipients onto Medicare, because it's so much cheaper.

Dr. BODENHEIMER: Well, we'll see what happens with that.

SUAREZ: Those two trend lines have to cross somewhere out in space, don't they?

Dr. BODENHEIMER: It's--you know, it's interesting that even a number of experts, including, for example, Health Care Financing Administration that runs Medicare, says that you could not expect to get savings in the Medicare program from the premium support feature that's being discussed by the Medicare Commission, so I'm not alone in thinking that this is not a good idea if we really want Medicare to be there for the millions of baby boomers who are going to reach retirement age about the year 2010, 2011.

SUAREZ: Robert Reischauer, let me bring you in here.

Mr. REISCHAUER: Well, just a few comments on the doctor's analysis. One is that we shouldn't be comparing these programs over a three- or a four-year period, but over a much longer period of time. One reason Medicare spending has slowed down so precipitously in the last few years is because in 1993, and again in 1997, the Congress enacted very substantial cuts in the program, and the question, looking forward, is will we be able to make cuts of a similar magnitude in the future? If not, one would expect that Medicare spending is going to accelerate once again.

The other real issue is the one that Diane pointed out, and that is that we have a program which was a pretty good program for 1965, but it's 1999. And

this program has a lot of holes and gaps in it, such that for the average elderly participant, half of their health-care spending is paid for by Medicare and half out of pocket or through a supplementary policy somewhere. This is hardly a comprehensive insurance policy. It's certainly not one that any American who is now covered by an employer-sponsored policy would want, because it doesn't have an out-of-pocket limit; it doesn't have--cover of prescription drugs; it doesn't cover a lot of preventive services that most workers and dependents are quite used to now.

So we really have to think of ways to modernize, make this a more adequate program while, at the same time, holding down the cost growth. And that's a very, very difficult thing to do.

SUAREZ: But are we really intending to create a comprehensive, all-embracing system out of Medicare? Right now, people are starting to change the tone with which they talk about Social Security and telling people who now are in their 30s and 40s, Look, this is not meant to be your entire retirement package. This isn't meant to be your pension. Think about it in another way.' So it sets a floor for the least financially well-endowed people, and then everybody takes it from there and goes up.

Mr. REISCHAUER: That certainly...

SUAREZ: Should we be thinking of Medicare in a similar way?

Mr. REISCHAUER: No, we shouldn't.

SUAREZ: OK.

Mr. REISCHAUER: I mean, that's certainly a way to go about retirement income. The government, through Social Security, provides the fundamental basis upon which you build a pension plan from your employer, some private saving of your own, the equity you've built up in your house and all of that. But when we talk about medical care, it really doesn't make much sense to have two or three policies covering your health-care needs, because it's confusing, it's complex, it's costly, not just for the participants but also for providers as well. And you can gain some significant efficiencies by bundling the entire coverage into one insurance policy. Now this is certainly what we found out in the employer-sponsored world.

There aren't a lot of people out there whose company provides them with health insurance who then go out and buy a supplemental policy. It isn't necessary, and it isn't an efficient thing to do.

SUAREZ: But your employer does give you a range of options at different costs, and you look 'em over and you decide depending on whether you've got dependents, depending on whether your children are still at home, what kind of care you're going to need, and you may go with the real bells and whistles plan or something a little bit more modest.

Mr. REISCHAUER: Well, that's precisely what Senator Breaux and a number of people on the Medicare Commission have proposed in this premium support idea, which would be to have a number of private plans--PPOs, HMOs, the various alphabet soup that we have now out there for types of insurance available as

well as standard Medicare. Standard Medicare isn't gonna disappear. And depending on the cost of these various plans, you will have different premiums that you pay as an individual, but you'll be able to choose among them.

SUAREZ: If you're just joining us, we're talking about Medicare this hour on TALK OF THE NATION. It is a program that is an increasingly heavy burden on general funds that are out of the taxes paid by American taxpayers. These are not totally sufficient--the 1 1/2 percent that you're paying out of your paycheck is not sufficient to pay the costs of Medicare. So we're looking ahead and wondering what Medicare might look like when millions more of you are retiring, when those of you who are already retiring later in the program and your health care may be even costing a lot more by then. (800) 989-8255 is our number.

Nampa, Idaho, is our first up. David, welcome.

DAVID #1 (Caller): Hello, Ray. I'm a family physician at Terry Reilly Health Services, a community health center here in Idaho, and my concern is regarding the commission's probable recommendation that they're gonna increase the age to 67. In my career and working with the uninsured in this country, I can think of scores of examples of people who are already 64, 63, who are waiting deferring essential medical care 'cause they can't afford it. As a particular example, I can particularly think of a particular 64-year-old woman with known heart disease who is developing worsening chest pain who refused to undergo cardiac catheterization because she couldn't afford it. She kept saying, Can't we wait six months?' Well, we waited six months...

SUAREZ: Until she was Medicare eligible, you mean?

DAVID #1: Well, she would have been, right, at 65. She was 64, and so she wasn't yet. And we kept our fingers crossed and, fortunately, she didn't have a heart attack that took her, but it could have very well been a much more expensive situation for everybody involved and maybe taken her life. Same thing with another woman that was developing symptoms of a developing stroke, kept saying, Can't we wait three months, six months, so I don't get my MRI?' And, again, same thing, somebody who's potentially at high risk of developing a serious medical problem not only in terms of cost but to that person's life is literally deferring care 'cause they can't afford it. So my question to our panel is, would the commission, if they do recommend raising the age to 65--what do they propose we do with the additional one to two million seniors who will become uninsured who are already sacrificing their own health care because they lack access and who are probably the ones who are most in need of that? What are we gonna do with those people?

SUAREZ: Diane Rowland?

Prof. ROWLAND: Well, I think you raise a very important point. One of the concerns about raising the age of eligibility is that we believe people without access to insurance--we know that as you get older, the cost of buying private insurance goes up; the kinds of policies you can get are often inadequate so that Medicare protection has been a very important piece of turning 65. And it's really quite different than being able to retire at age 62 and take a reduced benefit. If you've got an all or nothing situation, either you're insured or you're not insured. And I think one of the challenges of raising the

age of eligibility will be to try and figure out how to make insurance affordable for people during the waiting period. Yet, we know that we haven't been very successful in doing that anywhere else in our non-elderly population so that it is a major concern and one that I think will leave many people waiting even longer for that operation, as you've described.

SUAREZ: But, Thomas Bodenheimer, isn't that a problem no matter where you set the age limit? If, as some people have proposed, you dropped the age of Medicare eligibility, let's say, to 62, there would be 61-year-olds that might come to David's clinic in Nampa, Idaho, and have chronic conditions that need treatment for which treatment only gets more expensive if you wait, and as Diane Rowland calls it, an all or nothing program, there is a day when you're finally eligible for it.

Dr. BODENHEIMER: I certainly agree with David. And being a primary care practitioner in San Francisco, I have similar patients who are waiting to get on a program who are currently uninsured. I really think that it's necessary for everyone in this country to oppose the increase in the age of Medicare eligibility from 65 to 67. Studies have shown, number one, it doesn't really save that much money and, number two, it will increase the number of uninsured by over a million people. What our proposal is is to lower the age rather than to raise the age and, eventually, that Medicare is a good program to cover the entire population. It would solve the problem of the 43 million people who are currently uninsured. And if you have the entire population under a program such as Medicare, which has to be improved to have a much better benefit package, as our other guests have indicated, if you have the entire population under that program, you can budget the program and really try to reduce the rate of increase of health-care costs, 'cause we have to get health-care costs under control. Otherwise, the nation will not be able to afford the kind of care people need.

SUAREZ: Now, Robert Reischauer, you didn't used to be the head of the CBO for nothing. You know how to add figures up on a pad and paper. What does raising or lowering or keeping the same really do in terms of program eligibility?

Mr. REISCHAUER: Well, Dr. Bodenheimer's correct, that you don't save a tremendous amount of money because, of course, the people 65 and 66 are fairly healthy of the whole Medicare population. I agree with the other two panelists, that it would be a terrible mistake to raise the age of eligibility to 67, and it would create all sorts of problems in our system, not the least of which would be that you would find an acceleration of the trend that's already occurring, which is companies dropping their supplemental insurance for their retirees, because they will say, Good Lord, we're gonna have to pay the full bill for our 66- and 65-year-olds, and that's just gonna be too expensive, so we're gonna drop health-care coverage for our retirees.' And that will leave more people without supplemental insurance or paying the very high rates that Medigap policies now cost, which has become a real burden to many in that population.

SUAREZ: But today's 64 1/2-year-old, if what I read is right, is healthier than the 64 1/2-year-old from 1965 or 1935 or 1905 and can expect to live a lot longer as a result of getting to that age as a healthier person. Why isn't it actuarially rather than politically necessary to raise the age to respect--to respond to the different realities of what it means to be 64 1/2 in this country?

Mr. REISCHAUER: Well, the major reality is that we really should expect people to work longer. And if they work longer, they will be covered by their employer-sponsored health policy, those that work for a company which provides it, which is how most of us get our insurance. But we have not changed the age of initial eligibility for Social Security. We have just changed the age at which you receive unreduced benefits. And so I think some changes have to be made in the work area before we can consider what I think you're driving at, which is an increase in the age at which Medicare's available.

SUAREZ: Nampa, Idaho, thanks for your call.

You're listening to TALK OF THE NATION from NPR News.
David is with us now from San Francisco. David, welcome.

DAVID #2 (Caller): Yes, hi. There is a real simple solution to this, and it really--it's so simple that God knows the Republicans and Democrats would never go for it, and that's to raise the wages, either raising minimum wage or allowing the rise in wages overall. You mentioned that we're currently paying 1.5 percent in everybody's paycheck to fund these programs, and to raise wages in total, to raise the minimum wage and to raise other wages to an honest living wage would simply take care of this problem, and we wouldn't have to go through all of these machinations. But if you paid--if people have paid attention to the tort reform laws of the last 10, 15 years, especially those done during the Reagan and Bush administrations, these tort reform laws encouraged people who were injured on the job and subject to cancers and other types of conditions that were suing polluters to--and pollution is certainly going to be a major cost of what Medicaid, Medicare is going to go through in the next X amount of years. And the tort reform laws have actually encouraged the polluters to allow people to die before they do a payout.

And so if you look at much of the machinations which are going on in these discussions, they are actually encouraging the deaths of average US citizens because they don't want to pay--if you're familiar with tort reform, it's cheaper to pay for a dead person than it is to pay for someone that's gonna linger with a long-term condition, so if you just wait until they die and then you pay out their medical benefits--you know, their past benefits...

SUAREZ: But, David, wouldn't it have to be a sizable number of all the citizens in the affected class dying from environmentally related causes for this to really have an impact on the bottom line of managing Medicare?

DAVID #2: Oh, well, sure.

SUAREZ: You're making it sound like, you know, half of all old people are dying from environmentally related causes, and I'm just not sure that's true.

DAVID #2: Right out here--yeah, out here in San Francisco Bay area, we've got the highest birth or--excuse me--breast cancer instances in the country. We've got God knows, you know, how many pollutants--it's not safe to eat fish twice a month from out of the bay. Twice a month, and you're putting yourself at risk. I remember 15 years ago, the DDT in ducks was so bad that 17 states--they were telling duck hunters not to eat any ducks for--you know, shot in 17 states in the western part of the US. I mean, this is 15 years ago. Pollution is

critical at this point.

SUAREZ: Bob, I'm not trying to deny your point that pollution is critical, but it's a very roundabout way of reducing the health-care costs of Medicare to...

DAVID #2: Is to kill people? Yeah.

SUAREZ: No, is to go and do a wall-to-wall environmental cleanup. I mean, it just isn't gonna show up on the balance sheets for a very long time. Medicare will go out of business first before cleaning up the environment shows up on the balance sheet.

David in San Francisco, thanks for your call.

We're going to take a break. My guests are Thomas Bodenheimer, Diane Rowland and Robert Reischauer. We're going to take a short break, and when we return, we'll continue to talk to you about what's wrong with Medicare and how to fix it and we'll take more of your calls at (800) 989-8255.

At 33 minutes past the hour, it's TALK OF THE NATION from NPR News.

(Announcements)

SUAREZ: Welcome back to the program. I'm Ray Suarez. Today we're talking about the effort to improve the Medicare program, save it for the long term. My guests are Thomas Bodenheimer, a physician in private group practice in San Francisco, a clinical professor in the Department of Family and Community Medicine at the University of California, San Francisco. He's also co-author of Rebuilding Medicare for the 21st Century. Diane Rowland is here with me in Washington, executive vice president at the Henry J. Kaiser Family Foundation and the executive director of The Kaiser Commission On Medicaid and the Uninsured. She's also a professor of health policy at Johns Hopkins University. And Robert Reischauer is here in Studio 3A as well, a senior fellow in the economic studies program at the Brookings Institution and the chair of the National Academy of Social Insurance's project, Restructuring Medicare for the Long Term. He's also former director of the Congressional Budget Office.

Our number is (800) 989-8255. Linda joins us now from Ann Arbor, Michigan. Hi, Linda.

LINDA (Caller): Hi, Ray. I have a couple suggestions that I think would save money in the Medicare program. I'm a Medicare recipient. Excuse me. I'm also a--was a geriatric social worker. My first idea is that I have to have periodic IV drug treatment, and the only way Medicare pays for them is if I'm in a hospital setting, which costs over $ 1,000. And they won't pay for the service if done in my home, which would only cost $ 50. So I think that's one rule that needs revamping, is allowing patients to get more care in the home.

SUAREZ: OK. Linda, as someone who used to do this kind of work, how much qualification, how much training would a home health-care worker need to be able to minister to someone like you?

LINDA: Well, it would take a nurse to actually, you know, get the IV site,

but I can get a visiting nurse, so the IV treatments would only cost $ 50, and Medicare won't pay for that, but they will pay over $ 1,000 to have it done in a hospital setting.

SUAREZ: Thomas Bodenheimer, what do you make of that?

Dr. BODENHEIMER: Well, I'm surprised about that because we've had technology for a number of years that enables us to give home IV treatments, and Medicare recipients do receive these. I don't quite understand why this is a problem.

LINDA: Well...

Dr. BODENHEIMER: I think a larger problem is that, yes, there is money wasted in the Medicare program. That needs to be tightened up, and it's one of the things that should be done, rather than move to a voucher premium support program to try to reduce the rate of increase of Medicare expenditures, and certainly what Linda suggests is a way to go.

LINDA: The other suggestion in working with the elderly is that a number of those folks were people who were retired with health-care benefits from their employer, and they were pretty well-off financially, and they said they felt guilty getting Medicare because they didn't really need it. I would like to see a tax incentive program perhaps that would provide an incentive for folks who don't need it to surrender their Medicare.

SUAREZ: Diane Rowland, let's talk about that a little bit, because in your research, people were willing to look at sliding scale benefits and sliding scale payments for those who are more able or less able to afford it, having a different relationship with the program.

Prof. ROWLAND: Well, we certainly currently have people who get both Medicare coverage and supplementation from their former employer, although the employer's coverage is declining over time so that we're beginning to see an erosion of that double protection, so to speak. And I think what's most important about Medicare is to remember that people will have Medicare from the day they retire until the day they die and so you need to be sure that the scope of benefits there is maintained, and that if your employer goes out of business or is no longer around to provide those benefits, you would then be left without Medicare. So the universality of Medicare has really been one of its important protections, and as we look at the future, I think we need to look more at, within the Medicare program, doing things like income-relating premiums so that people with more ability to pay can pay more, but I would hate to violate the universality of Medicare coverage for over 65 population.

Mr. REISCHAUER: Linda's points, I think, are certainly well-taken, but there are always problems and unforeseen repercussions. The folks who say they don't need it don't need it because they had a pretty good employer-sponsored policy, but if those employers knew that they were going to have to pay the full freight rather than just supplement Medicare after the worker turned 65, they'd drop that coverage like a hot potato, and so you'd find them all needing Medicare very shortly.

SUAREZ: But Linda points out that there are wealthier and less wealthy seniors who are Medicare eligible and seems to be looking for a way that the

system itself would respond to that.

Mr. REISCHAUER: Well, in fact...

SUAREZ: I mean, is there a mechanism, a means testing system where the program can carry a heavier burden for those people less able to pay?

Mr. REISCHAUER: Well, the Medicare Commission is proposing or playing around with an idea that there would be added premiums for those who are 500 percent of poverty or more, and so it would be an income-related premium. These are very hard to collect, and you have to collect them really through the income tax system, and as soon as we mention the word tax,' politicians disappear from the room.

SUAREZ: Oh, Linda, thanks a lot for your call from Ann Arbor. Newtown, Pennsylvania, is next. Frank, welcome to the program.

FRANK (Caller): Yeah. I had a comment, but I wanted to ask ahead of time whether any of your panelists read The Washington Monthly, this one March, an article titled Bad Prescriptions: Why Privatizing Medicare May Be Hazardous To Your Health, by Kip Sullivan. And he suggested basically there should be a progressive tax--a Medicare tax on paychecks. It's not progressive now. And also he suggested that it should be financed out of the general fund some, a little, like it has been. We act as world policemen. You can't argue about bankruptcy if the general fund is paying it. The Pentagon never goes bankrupt. What's happening also, he says, is that what's going to happen is they're going to give you vouchers, and they're going to subsidize the insurance companies, and then few years, we'll switch to get prescription benefits, eyeglass benefits, hearing aid benefits, and then they'll pull the rug out from under them.

Now I want to ask you now, do you sh--anybody is interested--I don't know whether any of you have read The Washington Monthly there. I'm sure you have, Ray. But do you think that this plan to privatize medicine's a scam, to defraud seniors of good fee-for-service Medicare? That's my question.

Mr. REISCHAUER: Let me just make a few observations on Frank's statement. One is that we already use a lot of general funds for this program. The Part B Program, which amounts to about 40 percent of the total, is three-quarters paid for out of general revenues and one-quarter out of these monthly premiums that people pay. The rest is--the Part A Program, which is financed through the payroll tax, but the payroll tax is applied to all of your income--all of your earned income. Unlike the Social Security system, it doesn't have a cap on it, and so you'll find that Bill Gates is paying 1.45 percent of his wages, up to the millions and millions of dollars, so he is going to pay in significantly more than any of us will pay in, and yet the benefits he receives will really be the same. And so it's a system that has, in a sense, a degree of progressivity in it.

Prof. ROWLAND: But if I could add with regard to some of the kinds of plans that people might go into, he talked about--Frank talked about the fee-for-service program for Medicare, and there's a lot of fear that if you begin to put out options for various **managed care** plans with different levels of support and different types of benefits in those plans, that the healthier and the wealthier will elect to go into some of these **managed care** plans that may be

more expensive than the average, and they can afford to supplement them, but we will leave the sickest and the oldest and the frailest in the Medicare fee-for-service system, which will become more and more expensive and less and less adequate as you skim off the healthier, so that many people predict that under a premium support proposal, you could end up with as many as 40 percent of Medicare beneficiaries in the fee-for-service program accounting for two-thirds of expenditures, but not really being able to get the kind of benefits. So I think we need to look at all of the options on the table from the perspective of a program that takes care of our oldest and our sickest population to be sure that we're not leaving the frailest in the most minimal covered programs.

SUAREZ: Thomas Bodenheimer, it sounds like Frank agrees with you, in large regard, on the voucher system.

Dr. BODENHEIMER: I haven't seen the article, but I suspect that I would agree with at least the parts of it that Frank mentioned. I think that it's very important to realize that if you have a voucher premium support type system, you're basically privatizing the Medicare program in the sense that rather than people being in a public program, Medicare beneficiaries have to join either a public or a private health plan, but there'd be a lot of financial pressure to join a private health plan, and the problem with that is if you look at how HMOs have been working in the Medicare program in the last few years, there are a number of problems.

And I'm not an anti-HMO person, but if you look at some of the for-profit HMOs who tend to be the main ones operating in Medicare, they were introduced into Medicare to save money, but, in fact, every person in Medicare going to an HMO costs Medicare 6 percent more than people who stay in public Medicare, and that's because HMOs have tended to attract healthier people. Yet, they get plenty of money as though they were getting the average Medicare beneficiary. Administrative costs of HMOs are about 10 percent--something like that--as opposed to 2 percent for Medicare. So if we put the entire Medicare system toward a private voucher type system, the administrative costs will go up tremendously, profits will go up tremendously. One could almost call it a corporate welfare program for the private insurance industry. So I think that Frank is right, that a lot of taxpayers' money is going to be wasted if we move toward a privatized type of Medicare system...

SUAREZ: But very briefly...

Dr. BODENHEIMER: ...as Senator Breaux wants.

SUAREZ: ...Robert Reischauer, could the bait-and-switch that Frank talked about--basically getting a lot of people into the program and then starting to degrade the coverage provided by it--would that be possible under the way that such legislation would be crafted?

Mr. REISCHAUER: Well, the law now requires that private plans that do operate already in Medicare and enroll about 16 percent of the participants have to offer at a minimum the same benefit package that's provided through Medicare standard. And, in fact, almost all of them offer a richer benefit package. It's also true that the law that was passed in 1997 will reduce that overpayment that Tom talked about that's going to these plans now, and so while we might have been overpaying them in the past, that should be a problem of the past.

SUAREZ: Chicago, Illinois, is next. Sidney, welcome to the program.

SIDNEY (Caller): Oh, hi, Ray. Thanks for taking my call. I'm 76 years old and a retired physician, and I understand pretty well the rising costs of health care, but every industrialized nation in the world except ours has solved this problem of rising health-care costs through a national health plan, and I was recently in Spain where everyone is covered for health care and with no out-of-pocket costs. Now I don't know why we don't have a national health plan that would eliminate the high administrative costs of private health insurance like the rest of the world.

SUAREZ: But, Sidney, haven't...
SIDNEY: Why is that off the table?

SUAREZ: ...many of the countries that have the kind of comprehensive nationally provided health care started to experience the same kind of health-care inflation that we have in this country? I understand health-care costs have been rising very strong in Canada. Spain, you're talking about a country which is just now starting to move large numbers of people--millions at a time--into the European middle class, and I think it's probably fair to say that they will start to experience health-care inflation then, too, because the kind of things you ask for when you look at your life in a different way and when you're in this new industrial aristocracy, your needs start to go up. And they'll probably have the same kind of health-care inflation that we have in the United States and Canada. Maybe not at the same rate at the same time for the same number of (technical difficulties) but I can't see that that will not be a problem everywhere.

SIDNEY: Well, you know, I beg to differ with you, Ray. The Canadian system is still viable. Its--their health indices are far better than ours, as far as life expectancy and infant mortality are concerned, and the basic problem there as far as their costs are concerned is that the HMOs have moved into--for-profit HMOs have moved into Canada and are extracting profit, in that sense, from those people who join. And it just seems to me that a system which takes the profit out of health care is going to be far less expensive than the system that we now have. We have allowed the market to come in and turn health care into a commodity so that almost--are actually almost like being traded on the Big Board in New York.

SUAREZ: Sidney in Chicago, thanks a lot for your call.

SIDNEY: Thank you.

SUAREZ: You're listening to TALK OF THE NATION from NPR News. Oh, well. Sidney's still there for some reason.

SIDNEY: I'm here.

SUAREZ: Yeah. I'm pushing buttons like a madman here, Sidney, and nothing personal, but I'm...

SIDNEY: You're through talking to me then, huh?

SUAREZ: Yeah. I just--I'm pushing buttons, and you're still here. How is it

in Chicago today?

SIDNEY: Oh, the weather's fine. The sun is shining and the temperature's about 48. Pretty good.

SUAREZ: Well, thanks for calling us.

SIDNEY: OK.

SUAREZ: Let me see if I can get John from Koblenz, Germany, with us. Hi-ya, John.

JOHN (Caller): Hey, how you doing?

SUAREZ: OK.

JOHN: Can you hear me OK?

SUAREZ: Yes, I can. Go ahead, John.

JOHN: OK. First of all, thanks for taking my call. I tried calling you one time before, and I got hung up on. You pushed the wrong button or something. You were talking to me...

SUAREZ: Oh, man.

JOHN: ...I could hear you fine, but my question or my comment, I live in Germany. I've lived her for 15 years. I'm still an American citizen, but I live under the German system. And I'll tell you what, the socialized medical system, in my opinion, is far, far better than anything I ever experienced in the States. Doctors, I believe in the States, make too much money. How do I want to put this better? In basketball or professional sports--I don't want to compare doctors to sportsmen--they have salary caps because it was getting out of hand. Here we have a situation where the Medicare system is taxed with trying to overcome this hurdle of these rising costs instead of nipping the costs in the bud, maybe looking at a social system, to a degree, or a salary cap for doctors or certain operations. They just spring right over it and they try to get more money out of a cow that will not give any more milk.

SUAREZ: Well, John, can you see how it would be difficult to control health-care costs because health care is not a product like a lot of other products? Would you shop for the cheapest possible doctor to do your bypass surgery?

JOHN: No, not e--no, I wouldn't say I would shop for the cheapest doctor. I would also...

SUAREZ: I'll take that as a no.

JOHN: The market is saturated with doctors at the moment, much the same as the legal system is. I believe that. And I believe, like the woman said earlier--I forget her name. She was referring to, Oh, I can get this treatment at home cheaper than I can get it in a hospital, but that's my option with this system.' Medicare is, in effect, an insurance system. It works as an insurance

company should work, I believe, or an insurance policy. Why wouldn't people be able, like with an insurance company, to be able to go out and get an estimate? Or if they say, Well, I can get it done cheaper here,' why can't I get it done like that? Why...

SUAREZ: Well, John, that's a perfect question. Let me throw it to the panel. This not a commodity, I guess, is what's emerging, that you can control costs on that easily, Diane Rowland.

Prof. ROWLAND: But certainly, it's difficult to go out and shop for a doctor and a package of services between one hospital and another on price today. People go to a physician, get referred and often don't know the full cost implication of the care they're to receive. But what we're really talking about now in terms of controlling costs is not controlling it at the individual level, but controlling it in terms of which health plan you go into. And Medicare has had a fairly successful level record, as Bob Reischauer pointed out, in--as Congress has made changes in the payment levels, keeping their costs down. Medicare has a very low administrative overhead compared to private insurance. So we've had a lot of successes in managing costs, but we just need to look at some future ways of trying to build better and more modernized incentives into the programs, such as the home health-care example you got earlier.

SUAREZ: Well, Thomas Bodenheimer, you're the only physician on the panel today. Do doctors make too much money? Is that what's driving the cost?

Dr. BODENHEIMER: I think doctors do make too much money in many areas of the country, and I think it's very important, when we think about cost control, to think about what would work and what would not work. If you have a voucher type program, there's only one way in which that program will control Medicare costs, and that's by shifting more of the costs as Medicare expenditures go up onto beneficiaries. Now the average person over the age of 65 has an income--excuse me, not the average--79 percent of people over 65 have incomes less than $ 25,000 a year. They're already paying 21 percent of that income in health-care costs. They can't afford to pay more, so we shouldn't try to control health-care costs by shifting more costs onto beneficiaries.

SUAREZ: OK. And that--let me...

Dr. BODENHEIMER: They should control it the way they do it in Germany, with a budget.

SUAREZ: And Rob Reischauer, about 25 seconds.

Mr. REISCHAUER: The reason that costs are rising really has nothing to do with how fast doctors' salaries are rising. Really, it's technology and the ever-increasing capabilities of modern medicine that are pushing up costs. We could cut doctors' salaries. That would lower the costs at one point, but then they'd begin rising again.

SUAREZ: Robert Reischauer, thanks for being with us today.

Mr. REISCHAUER: You're welcome.

SUAREZ: Robert Reischauer is a senior fellow of the economic studies program at the Brookings Institution, chair of the National Academy of Social Insurance project, Restructuring Medicare For The Long Term. He's a former director of the Congressional Budget Office. He was here in Studio 3A, along with Diane Rowland. Thanks for coming by.

Prof. ROLAND: Thank you.

SUAREZ: Diane Rowland is executive vice president at the Henry J. Kaiser Family Foundation and executive director of the Kaiser Commission on Medicaid for the Uninsured. She's also a professor of health policy at Johns Hopkins. And Thomas Bodenheimer, thanks for being with us.

Dr. BODENHEIMER: It was a pleasure.

SUAREZ: Thomas Bodenheimer is a physician in private group practice in San Francisco and a clinical professor at the Department of Family and Community Medicine at the University of California, San Francisco, and he's co-author of Rebuilding Medicare for the 21st Century, a report from the national campaign to protect, improve and expand Medicare. He joined us from the studios of KPFK in Berkeley. Tune in tomorrow at this time for a look at how the US makes decisions to intervene militarily in trouble spots around the world. What is the national interest? In Washington, I'm Ray Suarez, NPR News.

LANGUAGE: English

LOAD-DATE: March 3, 1999

THE WHITE HOUSE

WASHINGTON

March 5, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings and Jeanne Lambrew

RE: Secretary Shalala's memorandum on the Medicare Commission

Attached is a detailed memorandum from Secretary Shalala expressing her concerns about the possible recommendations of the Medicare Commission. She specifically suggests that the Administration be extremely cautious about validating the Commission's plan in general -- and premium support in particular. She has concluded that the Commission's work is ill-specified, includes troubling policies, and would diminish our ability to influence the upcoming legislative debate on reforming Medicare. Her particular concerns about the plan are its:

- **Lack of specificity, particularly about premium support**. The Secretary's main point is that premium support is a new idea that has not been subject to vigorous specification or analysis, leaving unanswered questions about its design and potential effects. These details are fundamental to decisions about whether or not to endorse premium support. Moreover, a vote in favor of premium support without details will allow others to fill them in, using the Commission's endorsement as political cover for a different agenda for Medicare reform.

- **Existing details that suggest beneficiaries would pay more and be put at risk**. The HCFA actuary estimates that about 45 percent of the savings from the Breaux/Thomas proposal comes from increasing costs to beneficiaries. These include increases in premium, cost sharing, and eligibility age. The premium support provisions, as designed by the Commission, appear to raise the premium for fee-for-service by 10 to 20 percent, even in areas where beneficiaries have no private plan choices.

- **Lack of guarantee of defined benefits and omission of a prescription drug benefit.** Although Senator Breaux has indicated both that benefits would be defined and that he will attempt to add a drug benefit, the plan has yet to reflect these core Democratic issues.

- **Omission of the use of the surplus -- or any other revenue source -- necessary for adequate financing.** Premium support, which is one of the most contentious elements of the plan, does not appear to produce large savings in the long-run. The actuaries suggest that it reduces Medicare spending in 2030 by 2.5 to 3.1 percent. The proposal also does not include any specific financing plan and does not recommend using part of the surplus for Medicare.

- **Reliance on a new "Board" that assume partial responsibility for running Medicare**. The Department believes that creating a new bureaucracy to administer the managed care plans will reduce its ability to successfully enforce against fraud and would undermine a single point of accountability for the program.

All of your policy advisors appear to be coalescing around the conclusion that the Commission's work is unsalvageable. Clearly, Secretary Shalala is the most hostile to premium support. Even those most supportive of this concept (Treasury Department and CEA) believe that the ability to promote premium support will be undermined by any explicit endorsement of the Commission's work product. In other words, they believe that a good concept, poorly designed and portrayed, will undermine the prospects of a promising innovation to the Medicare program.

The NEC and DPC are coordinating a process for developing a recommended alternative Medicare reform policy for your consideration. Options will likely include your surplus proposal, an affordable and accessible prescription drug benefit, an income-related premium, and policies to modernize and add more competition to Medicare. We are also working on the details of what a more viable premium support proposal would look like. Clearly, a separate discussion about the advisability about unveiling such a package and the timing of doing so will follow.