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THE MEDICARE CHALLENGE: IT'S NOT JUST ABOUT PRESCRIPTION DRUGS

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BEFORE THE

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THE MEDICARE CHALLENGE: IT'S NOT JUST ABOUT PRESCRIPTION DRUGS

THURSDAY, MARCH 20, 2003

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
WASHINGTON, DC.

The committee convened, pursuant to notice, at 10:33 a.m., in room SD–628, Dirksen Senate Office Building, Hon. Larry Craig (chairman of the committee) presiding.

Present: Senators Craig, Hatch, Stevens, Smith, Talent, Breaux, Carper, Wyden, and Kohl.

OPENING STATEMENT OF SENATOR LARRY CRAIG, CHAIRMAN

The CHAIRMAN. Good morning, everyone. The Senate Special Committee on Aging will convene. I want to thank all of you for joining us this morning, but before we proceed, let me say that certainly our prayers today need to be with our brave men and women in uniform who are standing in harm's way in the Persian Gulf at this moment in behalf of this country and our freedom.

We are here today to begin to review changes in Medicare. I think I need to begin by stressing that prescription drug relief for seniors is needed, is critically important, and I support it wholeheartedly. However, the lack of drug coverage is just one of Medicare's several grave and urgent problems. It is our purpose here today to take a look at these other deep-seated problems, not just prescription drugs.

Like it or not, the hard reality is Medicare is very close to being fundamentally broken. As the Medicare Trustees reported just this week, Medicare costs, even without any drug benefit, will more than triple over the next 75 years, placing a tremendous burden on our children and grandchildren. Let me bring that statement into perspective, and I will read from the Trustees' 2003 report.

They have projected that Medicare costs will more than triple over the next 75 years. It sounds like a long way off, but it isn't. Even without any prescription drug benefit, growing from 2.6 percent of GDP today to 5.3 percent of GDP by 2035, and by 9.3 percent of GDP by 2077. To put this in perspective, all the Federal personal income tax that is coming in today amounts to 9 percent of our current GDP. So they are predicting, without prescription drugs, Medicare currently projected could go to 9.3 percent of GDP by 2077.

Moreover, the projected insolvency date for the Medicare Part A Trust Fund has advanced an additional 4 years. I am sure our colleagues will talk about that today.

Moreover, and despite very impressive progress made by our current panelist, Tom Scully, and his staff out at CMS, Medicare remains clogged by rigid bureaucracy and by complex regulations, regulations which are already beginning to drive doctors and other providers out of the program.

Finally, the Medicare program today is plagued by an outdated 1960's style benefit design that neglects not only prescription drugs, but also key innovations that are now increasingly common in the private sector, such as chronic disease management and protection against catastrophic financial costs.

It is critically important that whatever Congress may do about prescription drugs this year, these steps can and must be accompanied by serious movement toward putting the Medicare program on a more secure footing as the coming baby boomer retirement wave looms ever closer.

Towards this end, I am pleased that President Bush, Senator Frist, the ranking member of this committee, Senator John Breaux, and others have stepped forward with serious proposals aimed at doing just this. Especially attractive is the fact that seniors would be given the option of enrolling in a program similar to that currently enjoyed by Members of Congress and other Federal employees. Importantly, those seniors who are happy with their current coverage in traditional Medicare would be able to keep that coverage and their choice of doctor, but with protection against high drug costs and special relief to those with modest incomes.

Of course, none of these plans before us today offer a silver bullet and there will be very hard choices further down the road, no matter what Congress does this year, but I believe these approaches are solid first steps.

We are joined today by our first panelist, the Administrator of CMS, Tom Scully. We have our new Director of the CBO, Dr. Douglas Holtz-Eakin. Both are leaders on this current and critical debate and what they say before this committee and the record we build will be critically important.

Before we recognize our first witness, I also wanted to recognize the former Lieutenant Governor of my State, a health care leader in our State, former State Senator Jack Riggs. Doctor, nice to have you with us at the committee today.

First and foremost, with tremendous experience, and is making, as I mentioned in my opening comments, major reform there.

But Tom, before I recognize you, let me turn to my colleague, Ron Wyden of Oregon, who I work with on a variety of issues. He is a member of this committee and we are pleased that he is here this morning. Ron.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman, and let me commend you both for holding this hearing and associate yourself with your introductory comments with respect to our troops. They are on the minds of all of us today and our thoughts and prayers as they work so valiantly to protect the interests of all Americans. I appreciate your comments and holding this hearing.

I intend to work very closely with you and our colleagues, Mr. Chairman, on a bipartisan basis on this issue. As you know, Senator Olympia Snowe and I have in the last two Congresses introduced bipartisan prescription drug coverage legislation. I think it is important that we hold this hearing and look to the question of broader Medicare reform. The title of this hearing is, "The Medicare Challenge: It's Not Just About Prescription Drugs" I think probably only the minor change I would make in the title would be, "Don't Forget About the Critical Need for Covering Prescriptions As We Try To Go Beyond It," and I think we will have the chance to discuss that today with Administrator Scully, who I have known for a lot of years. He is one of the most thoughtful people in the country with respect to health.

I just have a couple of comments, if I might, Mr. Chairman. First, with respect to the broader question of Medicare reform, I am one who believes that you can have more private choices and more competition in the Medicare program if it is clearly defined within the Medicare program and accompanied by very strong consumer protections and vigorous oversight. I think that will be a big part of trying to pull together a bipartisan coalition here.

I happen to think we have a model for doing it. I don't pretend to be completely objective about it, having been the author of it, but the Medigap law which was written a number of years ago, when older people so often would have a shoebox full of worthless health insurance policies and now as a general rule have really only one good policy, is a pretty good model of how you can begin to bring in private choices into the Medicare program as long as it is within Medicare, No. 1, and accompanied by very vigorous, very aggressive consumer protection.

I noted just this last weekend Henry Aaron, not exactly an arch right-winger, said much the same thing. He wrote he is not unalterably opposed to private choices being a part of this, but that it has to have vigorous consumer protection and clearly defined oversight. I'd like to discuss this further with Administrator Scully.

The second thing I wanted to touch on, something of great importance in our part of the world, the chairman and mine, is payment equalization. There is tremendous concern in our part of the world where great efforts in Idaho and Oregon and Washington have been made to hold down costs.

For example, in my home town, more than 50 percent of the older people are in Medicare Choice. They are in plans that hold down the cost. What you get from patients, doctors, and other providers, to a person in our part of the country, which has been efficient is that the Federal Government penalizes you instead of rewarding you for holding down costs so one federal policies penalize efficiency and for holding down the costs in the Northwest. So I

want to discuss with Administrator Scully today some ideas for how to get at this.

One new concept that I would like to explore with the Administrator is something that I have been calling tentatively an efficiency bonus. There are parts of the country that have really taken steps to be more efficient, to hold down their costs, and maybe one way to get at this question of payment equalization so as to produce something tangible for those that really are going to great lengths to be innovative is to start looking at this in the context of an efficiency bonus.

But suffice it to say, this is an important hearing. At a minimum, prescription drug coverage can be a bridge to long-term Medicare reform. That is why it is so important that we have this hearing, Mr. Chairman, and I look forward to working with you as we have on so many occasions in a bipartisan way.

The CHAIRMAN. Ron, thank you very much, and let me apologize for being remiss in failing to mention the work that you and Senator Snowe have done in that area, of change and modification in these critical programs. Thank you.

Senator WYDEN. Thank you.

The CHAIRMAN. Director Scully, welcome to the committee. Please proceed.

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

Mr. SCULLY. Thank you, Mr. Chairman and Senator Wyden. Thank you for having me today and thanks for having this hearing. I think my own opinion is there needs to be a lot more discussion about these unbelievably complicated Medicare issues and especially how we potentially add wisely a giant new entitlement for prescription drugs.

Let me just start off first by saying you won't be surprised because we are old friends that I tend to agree with Senator Wyden on both counts. We should definitely have very strong—I think we should fix and modernize Medigap, but I think we definitely need very strong consumer protections and oversights, and obviously, we would like to have some more private choices for seniors. I am also very concerned and more than happy to get into the weeds on geographic misallocation or inequities in funding.

Let me just start off first also by saying I think the conflict in the Middle East affects all of us. My top physician advisor, Bill Rodgers, was called up and left today to go. So I think all through the government and all across the board, we are finding this affects all of us and all of our agencies.

I would also like to congratulate Doug, who I worked with a lot, and I think we are very lucky to have as a CBO Director. He was on the Council of Economic Advisors, and I can tell you, for a variety of reasons, we are fortunate for a lot of reasons, but he actually understands a lot about health care, which I think will hopefully make our already very good working relationship with CBO that much better.

Let me just quickly run through. Mr. Chairman, I don't think you wanted me to get into the details of our Medicare plan today.

I will be happy to discuss it in questions and I will go through it basically.

But I think fundamentally, our concern is Medicare is a tremendous safety net program. There is nobody over the age of 65 who is uninsured. There are a lot of wonderful things about Medicare. But it is, in our opinion, a model that has a lot of flaws. We fundamentally fix prices for every hospital and every doctor in Boise or Milwaukee or Portland. We don't talk enough about differences in quality and people don't have any idea who does the best heart bypasses in Milwaukee, where I was last week. It is a wonderful, terrific program, but it is particularly inflexible and not particularly focused on improving quality or making the health care system more dynamic and I think it has a lot of flaws.

We are totally supportive, as obviously you know, of putting a prescription drug benefit in place. Adding a $40 billion benefit, however, needs to be done carefully. We also think that while you are going to enhance Medicare and give seniors what they want most acutely, which is prescription drug coverage, it would be wise to fix some of the flaws in the Medicare program and probably try to fix a lot of what we see to be the flaws in it.

Let me just run through—you mentioned the Trustees' Report, just to show some of the problems you have with the Medicare program. It is a great program, but some years we have 1 percent growth, some years we get 12 percent growth, and generally, as an Administrator, I would tell you, and I think probably Nancy and Linda and Bruce Vladek and many of my other friends who have had this job in the last 10 or 15 years will tell you we rarely know why.

Just to tell you a couple of the trends that came out last week was we calculated the numbers from 2002 which showed up in the Trustees' Report. Overall spending last year in Medicare grew by 8.5 percent, much higher than we expected a few months ago. Hospital spending increased by 9.8 percent in 1 year, about 4 percent—more than 4 percent higher than we expected 6 months ago. There are a variety of reasons behind that, some of which I will get into in a minute.

Home health care spending went up by 24 percent. There are some aberrations, as you know, between how we switch from Part A to Part B, but the baseline spending increased in home health, which was just reformed a couple of years ago and up 14 percent. Hospice spending, a wonderful program for people near the end of their lives, went up 24 percent last year.

Physician spending, amazingly, even though we spent a lot of time trying to fix and the Senate and Congress just added $54 billion back into the baseline, we cut the base doctor payments last year by 5.4 percent, obviously a huge controversy in the Medicare program. I happen to think it was wrong and was a strong advocate for fixing it. But at the same time, we reduced the average payment last year by 5.4 percent per doctor. They responded by increasing their volume of services 8 percent. It was projected to be 2 percent. So despite that cut, even though we reduced their payments last year, overall physician spending in the program went up by 7 percent, which was higher than it was expected to be even if

we paid the right amount. So behaviorally, there are some strange things going on there in the program.

Durable medical equipment, long a problem in the Medicare program, grew by 20 percent last year, despite the fact we made very strong and aggressive enforcement efforts in the program to try to reduce that. Wheelchair sales went up by 28 percent last year, which does not remotely track the growth in beneficiary levels or acuity.

Prescription drugs, on the part of Medicare that we pay for, which is about $8.7 billion, we pay for prescription drugs in hospital outpatient departments and in physicians' offices when it can't be done at home. That spending went up 25 percent last year—25 percent, which is obviously a model to say we should be concerned about how we create prescription drug benefits for the more traditional outpatient prescription drug services.

We frequently can't track what is going on in this program, and I somewhat—maybe I shouldn't joke and refer to it as kind of "whack-a-mole." We find one problem and the next one pops up the next day and it is a constant situation in this program.

The most recent enormous abuse that we didn't understand was hospital outlier payments. We spend about $90 billion a year on inpatient hospital services. We set aside, with Congress's direction, 5.1 percent a year for high-cost, high-acuity cases, generally for hospitals that have highly complex patients, because we pay on an average basis and if a patient is expected to stay in a hospital for 6 days and ends up being in the hospital for 60 days, obviously, we compensate the hospital more.

Unfortunately, some hospitals found an enormous loophole in this program, about 325 hospitals, and we spent about $2 billion more last year than we expected without knowing it until very recently, and in each of the last 4 years, we spent between $1 and $2 billion more than Congress expected or authorized us to spend without even understanding it, due to the fact that some hospitals—it is a very complex system. A number of hospitals found ways to bill us way more than they ever should have even remotely imagined they were going to get paid for.

Just to give you one example of a hospital in California that received $50 million in base payments for hospital services last year. Had they been the average hospital in the country, they would have gotten $2.5 million of add-on payments. They actually got $75 million of add-on payments. This is hospital outlier payment policy.

The point being that there are a lot of very unusual things going on that annex this program. It is not a particularly flexible program, but we frequently don't understand what is going on and I think there are a lot of reasons to modernize it, not just the new structure under what the President proposed, but also we need to continue to look at improving the Medicare program.

Senator Wyden is an expert and obviously created a lot of the Medigap, knows that we already have even in the private existing Medicare program, the bulk of the beneficiaries, the 89 percent of seniors and disabled that have traditional Medicare, Medicare covers 47 percent of their actual costs. Most of those people don't realize it, but they send a supplemental premium check for Medigap off to Blue Cross of Oregon or CIGNA or United Health Care or

Blue Cross of Wisconsin, usually for $150 to $200 a month, which is the average range for a non-drug premium, to pay for supplemental benefits. So most seniors have a hybrid already where they have a government-run program that is the basis benefit and a usually not-so-well-structured supplemental private sector insurance program that provides their other benefits.

So I would totally agree with Senator Wyden that what we need to do is look at the bottom-line cost for seniors, how we provide them with the best benefits, the best drug benefits most efficiently, and more importantly, give them even more consumer protections than the enhanced consumer protections, better than they used to be in Medigap.

But there are a lot of ways to look at this. The President sent up his framework for reform, obviously without all the details. That was with lots of guidance from Congress. Some people want us to send up five talking points. Some people want us to send up a 40-page plan with every detail and every dollar, and I think the President wisely proposed the middle course. Congress legislates and the President decided that we are going to send up a framework for philosophically how we thought the program could be improved and that we would work with Congress to fill in the gaps and that sending up a detailed bill would not be a particularly helpful or useful way to get the legislation done.

I think the bottom line for the administration is we would very much like to get prescription drug reform done and Medicare reform done, and many of us have been working on this for 20 years and absolutely nothing has happened. In our minds, the worst of all worlds would be for us to get to the end of this year and the end of this legislation and once again flame out and have nothing happen.

So we are determined. Obviously, we have a construct that we think will work. The House passed one last year. There was a tripartisan bill and other bills in the Senate. We would like to work together to come up with a formulation that we think would work, but I would say that the President's—the one firmly held belief that I know he has is that adding a drug benefit alone without looking at the underlying structure of the program and improving it would be a large mistake.

So we are committed to improving and modernizing the program. The basic framework, which I will just run through very briefly, is that the old fee-for-service program, the President has said repeatedly, if you like Medicare, it will never change. In fact, I can tell you the details, but the way it is structured is that the premium would also never change. So even if people moved out of traditional Medicare into new Medicare, the premium forever more will be structured as if nothing changed. So we are not in any way disadvantaging existing Medicare beneficiaries, and in fact, they would get a fairly substantial additional subsidy for a basic drug package for free.

In addition, what we have tried to do is take the best of what we saw in the Federal Employee Health Benefits Plan, which does provide coverage for everybody. Even a postal worker in Alaska or rural Montana can get Federal Employee Health Benefits coverage, or a park range. We believe that we took the best that we saw in

the Federal Employee Health Benefits Plan and Tricare, which is the Defense Department plan, and tried to come up with a model that would provide people with private PPO, fee-for-service options in the rest of the country.

In the last 10 years, the kind of flexible fee-for-service PPO option has taken over the commercial sector. We have moved from about 20 percent of the people in those types of plans in under age 65 to 70 percent. It has completely taken over the commercial market across the country. HMOs, which are for some people wonderful, but not for everybody, have largely been static the last 10 or 15 years. But there were people who have demanded, both in the Federal Employee Health Benefits Plan and across the commercial sector, is the kind of ability to go to any doctor they want, any hospital they want, but to have some differential copayments. If you happen to go to a Blue Cross plan and you go to an in-network doctor, you might pay $10 or $15, and if you go out of network, you might have to pay a 20 percent copyament and a higher rate. But you can go to any doctor you want, any hospital you want with differential incentives to improve behavior and improve performance of the plan.

We think that is what consumers want. We think that is what they want when they are 64 and we think they want the same type of choices when they are 66. We have no desire to take away any of the choices that people have now and do anything to limit existing Medicare coverage. But we believe that if consumers are given these options, it will help them get better choices. It will improve and modernize the Medicare program and make the program work better.

We also think the Medicare+Choice program, which works very well in Oregon, I feel very strongly it is not for everybody. It has been shrinking over the years for reasons I am certain we will get into in a few minutes. It is down to about 11 percent of the program. It peaked at 18 percent in 1997. It is tremendous for people who can't afford to send a $200 Medigap check off to Blue Cross of Oregon. If you are relatively low-income and you can't afford the cost, you generally get some drug benefit, you get drug costs, and you live with an HMO. It is not for everybody, but it is overwhelmingly preferred by people that are low-income and heavily minority population and we think it is a choice that needs to be preserved and enhanced and saved. It is never going to be for everybody. Even under the President's plan, we never envision it growing to more than about 15 percent of the program.

So we are not talking about pushing anybody into HMOs. We are talking about trying to mimic what works in the best parts of the commercial market and give the same choices to seniors that we think that they are—especially younger seniors, as they hit 63, 64, 65, they are happy with the programs they have. Dropping out of that and moving into a less-flexible Medicare program may not be the best option for them. We also think it is the best way to make sure we provide a prescription drug benefit efficiently to people.

But we are very—obviously, the reason the President set up a framework is because we believe you have to work with Congress to get it done. We have some strong views about how it should get done, but we want to work with the committees and with the

House and the Senate to make sure that we don't end up getting to the end of the year with no result, which would be the worst outcome, we believe, for everyone.

I have a number of things in my testimony, Mr. Chairman, but given the number of members that are here, I would probably be much more useful to answer your questions and to get into details on that. Thank you very much.

The CHAIRMAN. Administrator Scully, thank you very much.

[The prepared statement of Mr. Scully follows:]

TESTIMONY OF
THOMAS A. SCULLY
ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
ON
MEDICARE REFORM AND PRESCRIPTION DRUGS
BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING
MARCH 20, 2003

Chairman Craig, Senator Breaux, distinguished Committee members, thank you for inviting me to discuss modernizing and strengthening the Medicare program. President Bush believes our nation has a moral obligation to fulfill Medicare's promise of health care security for America's seniors and people with disabilities. To meet this obligation, the nation must act now to bring Medicare into the 21st Century. The President, the Secretary and I are urging Congress to provide more choices and better benefits to Medicare beneficiaries. In modernizing and improving what is now a $270 billion program, we need to combine what we know are the strengths of the Medicare program with the best of what we know from the current private health insurance market and the Federal government's experience in running the largest employer-sponsored health insurance program. This is how we can best serve our current and future Medicare participants. I look forward to discussing with you today ways to improve the current Medicare system and to modernize the program's benefits.

Since Medicare was enacted in 1965, it has provided health care security to millions of America's seniors and people with disabilities. As successful as the Medicare program has been, it has not kept pace with decades of dramatic improvements in health care.

Medicare's current benefits package does not cover prescription drugs. Equally important, however, is that the program has not provided timely, consistent coverage for many modern technologies and preventive treatments. It also does not always protect beneficiaries against the high costs of treating serious illnesses, and it imposes unnecessary regulatory burdens on providers and patients. As a result, seniors may not always receive the most up-to-date treatment for their health problems. When Medicare was established in 1965, health care usually meant hospital care. Today, we understand the importance of preventing seniors from getting sick in the first place, but Medicare imposes cost-sharing requirements on preventive benefits that can keep beneficiaries from getting the treatments they need. As a result, Medicare beneficiaries today lack many of the choices and benefits available to millions of other Americans.

In 1965, Medicare was modeled after the private market at the time -- largely Blue Cross plans. These plans typically offered little or no coverage of preventive care and usually did not include a prescription drug benefit. Times have changed, but Medicare has not changed with them. The coverage that most Americans have today gives enrollees more choice and greater flexibility. It gives enrollees the option of receiving care at reduced cost from networks of preferred providers, and it covers prescription drugs. If we were creating the Medicare program today, it makes sense that we would model the program after what consumers are demanding from today's health care marketplace. We must bring Medicare into the 21st century: to expand its coverage, to improve its services and to give seniors more control and flexibility over the health care they receive. The time to make these changes is now. With health care costs on the rise and the Baby Boom generation nearing retirement, Medicare faces serious financial challenges. The Medicare Trustees report, released this week, cites continuing increases in the cost of care. For example,

according to the report, Medicare expenditures for inpatient hospital care increased by 9.8 percent in 2002; Part B spending increased by 11.6 percent; home health went up 28 percent. So, not only is it important to offer modern, innovative health care choices for seniors, but to do so in a way that is fiscally responsible and does not make Medicare's finances worse off.

Seniors, particularly low-income seniors, need prescription drug coverage now -- it's long overdue -- and it is a big priority for President Bush and Secretary Thompson. But we must also update the program's structure to make the best use of today's modern health care delivery methods to maximize the benefits for current and future participants while addressing the long-term sustainability of the program. All Americans should be able to choose a health care plan that meets their needs at affordable prices. When people have good choices, when people are given different options, health plans have to compete for business -- which means higher quality and better coverage.

We look forward to working with Congress on legislation this year to bring more choices and better benefits, including drugs, to Medicare. Moreover, the President has offered a framework for modernization that would make sure that low-income seniors -- some of the most vulnerable Medicare beneficiaries -- receive significant additional financial assistance for the cost of drugs. The President has also proposed immediate savings through a Medicare-endorsed prescription drug card, which would offer seniors discounts between 10-25 percent, which is supplemented for low-income seniors by $600 to help purchase drugs. The President has committed up to $400 billion over the next ten years in his FY 2004 budget to pay for modernizing and improving Medicare, and has offered a framework that will give <u>all</u> Medicare beneficiaries access to:

- **Prescription drug coverage** that enables seniors to get the medicines they need;
- **More choices of more health care plans** -- just like Members of Congress and other federal employees enjoy today through the FEHBP;
- **Continued choice of doctors and hospitals** for the treatment and care they need;
- **No cost-sharing for preventive services** such as screenings for cancer, diabetes and osteoporosis; and,
- **Protection from high out-of-pocket costs** -- a huge gap in Medicare that threatens to rob seniors of their savings.

For too long, political conflicts have kept our nation from bringing the benefits of modern health care to Medicare. We are calling on members of Congress to work together with us to pass legislation this year -- America's seniors need relief, and this is the year to finally get it done.

MORE CHOICES -- INCLUDING TRADITIONAL MEDICARE

We believe Medicare beneficiaries should be given more choices in how they receive their health care—and these choices should be strictly voluntary. For example, those beneficiaries with retiree benefits from their former employer could keep their current benefits. Those seniors who are happy with their current coverage in traditional Medicare will be able to keep that coverage and receive help with the high costs of prescription drugs for no additional premium. **Traditional Medicare will continue to be there for those seniors who want it.** But all seniors should be offered different options, a range of options from which to choose, in both the public sector and private markets. And all of these choices -- all of them -- must include access to prescription drug coverage.

Improvements to Medicare should not force changes on today's seniors who are satisfied with the current system. But seniors who want more choices and better benefits will be able to select options providing additional benefits. Seniors will have the chance to select the health plan that fits their needs best -- people want the same options at 66 years of age that they want at 64. Under the President's proposal, beginning in 2006, Medicare beneficiaries will be given the choice of three options: Traditional Fee-For-Service Medicare, New Enhanced Fee-For-Service Medicare and Medicare Advantage.

TRADITIONAL MEDICARE

As I mentioned earlier, the President's framework provides beneficiaries with the option of keeping their existing Medicare coverage. Should a beneficiary select the traditional benefit package, they will receive their current benefits, along with additional protection against high out-of-pocket prescription drug expenses. This protection will be provided at no additional cost to beneficiaries. In addition, beneficiaries in traditional Medicare will continue to be able to receive supplemental coverage from other sources, such as former employers, Medicaid or Medigap. The President's framework also adds two Medigap plans to the ten that are available currently. The new plans will include prescription drug coverage and additional protection against high out-of-pocket expenses. Those enrolled in traditional Medicare also would have the option of utilizing a new prescription drug card that would provide discounts of 10-25 percent off drug costs.

ENHANCED MEDICARE

The second option outlined under the President's framework is Enhanced Fee-For-Service Medicare, which makes a number of structural changes to Medicare that would vastly improve seniors' flexibility to tailor health care plans to fit their needs. Under this option, beneficiaries would have a choice of health plans like the system that provides reliable health insurance options to all Federal employees in the Federal Employees Health Benefits program. Like traditional Medicare, the government would cover most of the cost of coverage and beneficiaries would have the choice of doctors and hospitals. Beneficiaries could go to any Medicare doctor or hospital, but those who seek treatment within a plan's network of preferred providers will pay less. Enhanced Medicare includes an improved benefits package, which would provide full coverage of cost-sharing on preventive benefits and protection from high out-of-pocket costs of inpatient hospital care. Beneficiaries in Enhanced Medicare will pay a single deductible, replacing the current Part A and Part B deductibles in traditional Medicare. In addition, those enrolled in Enhanced Medicare will have no hospital cost sharing for their first two inpatient hospital admissions in a year. Beneficiaries also will have the option of enrolling in a comprehensive prescription drug program that includes coverage of prescription medicines and protection against high out-of-pocket drug costs. Plans would be free to structure their benefit packages differently, provided they meet a basic federal standard, in order to provide beneficiaries with a broad selection of options. Low-income beneficiaries will receive additional assistance for no extra premium and will receive subsidies to limit their co-payments. We believe increasing beneficiaries choices among providers will give incentives to improve customer service and quality in the nation's health care system.

MEDICARE ADVANTAGE

The third option under the President's framework is known as Medicare Advantage. Medicare Advantage is a way for beneficiaries to enroll in low-cost and high-coverage managed care plans. Currently 5 million Medicare participants choose to get their benefits from such plans (currently Medicare+Choice). In fact, according to an April 2002 study by Ken Thorpe at Emory University, low-income beneficiaries are disproportionately likely to enroll in Medicare+Choice. Many such beneficiaries may have difficulty affording the average Medigap plan that includes premiums over and above the Part B premium. The most popular Medigap plans have monthly premiums ranging from $91 to $161 without drug coverage, and from $123 to $256 for some drug coverage. Moreover, minority populations have shown a strong preference for Medicare+Choice, with 40.3 percent of African American beneficiaries and 51.6 percent of Hispanic beneficiaries enrolled nationwide. Medicare Advantage plans will offer broader coverage at a lower cost than the combination of Medicare and Medigap plans that many seniors choose. Health plans that participate in Medicare Advantage will offer benefit packages similar to the ones available in Enhanced Medicare, with protection against high out-of-pocket expenses and improved cost-sharing of preventive benefits.

Medicare Advantage plans would provide participants with Medicare's enhanced basic benefits package and drug coverage. However, the Medicare Advantage program offers improvements to the current Medicare+Choice system by providing supplemental premiums and subsidies for drugs, thereby avoiding carve out for that coverage in the benefits package, which is what typically occurs in Medicare+Choice plans today. Participants who select more efficient plans will benefit from savings, and some participants in the most efficient plans might pay no

premium at all to the Medicare Advantage plan and could potentially qualify for a rebate on their Part B premium. Creating a system in which different types of delivery systems compete to cover beneficiaries will result in a marketplace where plans in each system will have strong incentives to provide the most efficient and highest quality care. Just as in Enhanced Medicare, low-income seniors could pay no additional cost for a drug benefit offered through Medicare Advantage plans.

PROVIDING IMMEDIATE ASSISTANCE

All comprehensive Medicare drug benefit proposals, including those offered by Democrats and Republicans will require significant lead time prior to implementation. Given that seniors need help now, the President's framework is designed to provide significant and immediate assistance to low-income beneficiaries with their prescription drug costs. To ensure that seniors are provided help as soon as possible, the President will ask Congress to immediately provide all seniors with a drug discount card that is estimated to achieve discounts of 10 to 25 percent on the cost of individual prescriptions by pooling the buying power of Medicare participants. In addition to the discount card, the President's plan would provide low-income seniors with a $600 annual subsidy for drug coverage, which will continue for low-income seniors who stay in traditional Medicare. This subsidy can be added to their discount card and used at the point of sale, or alternatively paid to existing Medicare+Choice health plans that enroll low-income seniors and provide them with prescription drug coverage.

The President's framework, however, is exactly that -- an outline. There are a number of things to consider and many details of the proposal need to be developed with the help and input of

Congress. We want to work out a long-term solution for seniors while being cognizant of the long-term fiscal impact of the decisions we make. Therefore, the Administration is determined not to add a new drug benefit to Medicare without significant reform of the program's existing structure.

REGULATORY AND CONTRACTOR REFORMS

As I hope I've made clear, strengthening and modernizing Medicare is one of the Administration's top priorities. In addition to helping craft the President's framework, we at CMS are working to modernize and strengthen the Medicare program administratively through updating and streamlining Medicare's regulations and administrative procedures. The Secretary's Advisory Committee on Regulatory Reform developed more than 250 specific recommendations, a majority of which pertain to CMS. We are addressing a significant portion of the Committee's report by reducing the burden of inefficient, as well as unnecessarily complex and confusing regulations. We have already implemented recommendations made by the Committee to reduce the burden of data collection on beneficiaries and providers. These are common-sense solutions to ensure that health care professionals can spend more time with patients and less time with paperwork.

Another integral part of our regulatory reform efforts is our work to improve performance through provider education and outreach. We have expanded our Local Provider Education and Training program (LPET). This year we increased funding for LPET by 30 percent, which is targeted to respond to problems identified through the review of claims. Providers are receiving more education related to their claims submission. Clinicians deliver most of the education, and

respond to specific coverage or coding issues. Contractors meet with providers in group settings, individually, or communicate using the Internet. As a result, our contacts with the provider community are more collaborative and productive.

Clearly, we have worked diligently toward eliminating unnecessary regulatory burdens in Medicare and improving our management of the private-sector contractors that process and pay Medicare claims. The Administration's primary goals for Medicare contracting reform include providing CMS with more flexibility to adapt its business model to meet the evolving needs of the Medicare program and bringing competitive discipline to the world of Medicare administrative contracting. We also believe that contracting reform will provide opportunities to improve communication between CMS, contractors and providers, and will promote our ability to reward contractors that perform in an excellent manner.

APPEALS

Another area we are working hard to reform is the Medicare appeals process. As required by law, we provide a multi-level process for Medicare beneficiaries, providers, and suppliers to appeal when they disagree with a Medicare contractor's decision to deny Medicare claims for items or services. We recognize the need to make this process more efficient and accurate. Currently, we are working aggressively to implement the Medicare appeals reform as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Also, the President's Budget proposes legislative changes to give HHS the authority to streamline and make more efficient the appeals process in the BIPA framework, and includes funding to cover implementation costs. The Budget also proposes transferring the adjudicative

function performed by the Administrative Law Judges at the Social Security Administration to CMS and we are proceeding aggressively toward that transfer. We have already had extensive discussions with about transferring the Medicare hearing function to CMS. We are moving forward and have published Notices of Proposed Rulemaking (NPRM) on both sections 521 and 522. The NPRM for BIPA section 522 was published in the Federal Register on August 22, 2002. The comment period ended October 21, 2002. The NPRM for BIPA section 521 was published in the Federal Register on November 15, 2002. The comment period ended January 14, 2003. We are currently reviewing the comments.

CONCLUSION

President Bush, Secretary Thompson, and I are determined to work with Congress to modernize Medicare and add a drug benefit to the program. This Administration has started the process by reaffirming our commitment to devoting substantial new resources to Medicare. The President has also offered a strong framework for building a comprehensive, effective Medicare modernization plan that will provide America's seniors with a much-needed drug benefit and offer them the same kind of choices and flexibility that federal employees, and frankly, most other Americans enjoy. The Administration is determined to work with Congress to get this debate moving forward, so that seniors now and in the future get the type of Medicare program they need and deserve.

Thank you for the opportunity to discuss this very important topic with you today. I hope that I have been able to express the Administration's dedication to strengthening Medicare, as well as our commitment to work with you to do so. I look forward to answering your questions.

The CHAIRMAN. Before we turn to questions of the Administrator, let me recognize my colleagues who have now joined us, and I will do that in order of which they entered the room. Senator Kohl, do you have an opening comment you would wish to make?

Senator KOHL. No, Mr. Chairman.

The CHAIRMAN. Thank you for being here. We think this is a very important hearing in relation to the other aspects of Medicare.

My colleague from Alaska, the senior Senator from Alaska, Ted Stevens. Ted, do you have any opening comments?

STATEMENT OF SENATOR TED STEVENS

Senator STEVENS. I do, but before I start, I want my colleagues to recognize the problems that are developing here and I would ask you all to help us. I am calling the Architect now. That door is closed and that door is closed. In the period that we are in now, we have three exits from almost every room as a matter of security. As chairman, I want these doors open today, and I would ask someone to get a hold of the Architect and tell him to be in my office, Room 522, in a half hour. There is no sense in this. These have been claimed by staff on either side of these doors and therefore are safety, and I want them open today.

Now, nice to see you again, Mr. Scully. I am pleased the chairman is holding this hearing and I appreciate being here and your comments. I think that we have got to revamp Medicare. It is still a 1960 model trying to deal with the new century's challenges and it just won't work.

I am one of the authors of the FEHB and I am pleased to hear your comments concerning that as a prospective prototype for dealing with the changes in Medicare. I do believe that is where we should start.

But I have got a specific problem that I wanted to chat with you today. When I was last home, I had a meeting with a series of Alaska doctors, some of whom I have known since they were babies, and they were all responsible for a recent announcement in Anchorage that no family care doctor would see seniors. There are no seniors that can get access to family care practice today because of the problems that they detailed to me at that time.

Medicare payments only cover about 40 percent of their total costs, and when a doctor in the Anchorage area sees a senior, they must really subsidize the system to the extent of 60 percent of the average costs of just seeing a patient. I think the system is broken down when that happens.

When I came back, I did, with my colleagues' help, we put some additional money in the omnibus bill. We actually started off with an offset for the bill itself, an across-the-board cut to get that matter to conference, but it doesn't come close to fixing the problem of access that I heard about in Alaska, and they still will not see seniors because they cannot afford to subsidize that.

A doctor I have known—it is interesting, because her mother used to be part of my Alaska Senate staff—gave me the information about her charges for an intermediate mid-level exam. Medicaid pays $75 for that service. Blue Cross pays $112 for that service. Medicare pays $42 for the same service. Now, I can't under-

stand a system that was so discriminating against seniors. I hope that you will take a look at this and see what we can do.

It may be that the fantastic problem we have is related to the reason that we pay civil servants in Alaska 25 percent more than what they get in what we call the "South 48." All Federal civil servants in Alaska get a 25 percent bonus to base pay to meet the cost of living in Alaska, which is substantial. Everything we eat and wear and lives in comes in from what we call outside. It comes in by boat or by air, and the cost of living in Alaska is at least 25 percent higher than Seattle.

As a consequence, though, we got the Veterans Administration to study the situation and they set up a special payment system for Alaska, which you may be involved with, I don't know. It is linked to private charges and it pays for Alaska veterans 90 percent of the private charges. Now, some of those are seniors, some of them aren't, but as a practical matter, it is a system that seems to be working now.

But the seniors are in real difficulty. I really don't know what to do about this because I don't have an immediate band-aid this year. I don't know how to get those doors open for the senior citizen, and we don't have a lot of them. Most of the people I have known, my age, that have been smart enough to retire, are down in the sunshine country and they don't spend much time in Alaska in the wintertime or year-round.

I do hope that you can help us, though, for those people who are there, are unable to afford to move, to go where it would be easier to live, and they are now denied access to this primary care. It is the saddest thing I can think of and I hope you will work with me and ask your staff to work with all of us to see if there isn't some interim solution to taking care of the senior citizens that do seek private care through the family practitioners in Alaska.

We don't have any HMOs in Alaska. There are none there. There are not enough of us to support an HMO in any one place. So I would hope that we can find some way to deal with this.

Again, maybe we should make them eligible for FEHB or something, I don't know. There might be some answer somewhere along the line that we can take care of the system, and I would appreciate your help if you would help us. Thank you.

The CHAIRMAN. Well, thank you, Mr. Chairman.

I see Tom taking notes there, so let me turn to Gordon Smith for any opening comments he might have before we respond to those concerns.

Before you leave, Senator, a new survey that came out with physicians, AMA, in January found that 50 percent of physicians are now saying they are planning to limit their Medicare participation either by not taking new patients or by dropping them out entirely.

Senator STEVENS. My own family practitioner for many years called me and said, "I am sending you back your files. You are too old. I can't afford you." [Laughter.]

The CHAIRMAN. Let me turn to my colleague from Oregon, Gordon Smith, who has joined us.

STATEMENT OF SENATOR GORDON SMITH

Senator SMITH. Mr. Chairman, in the interest of time, I will put my statement in the record. I have a question regarding SHMOs or HMOs unique in Oregon and very helpful to the elderly, frail, and so I am going to ask that at the appropriate time.

[The prepared statement of Senator Gordon Smith follows along with prepared statement of Senator Orrin Hatch:]

PREPARED STATEMENT OF SENATOR GORDON SMITH

Thank you, Mr. Chairman for holding this hearing today. Mr. Chairman, I would like to commend you for your leadership in recognizing the need for a global approach to Medicare reform, while recognizing the importance of expanding Medicare coverage of prescription drugs. Medicare reform must be focused on modernizing the program to make it more responsive to the needs of today's beneficiaries. That means making the program more responsive to chronic illness.

The 2001 Institute of Medicine report, Crossing the Quality Chasm, indicated that, and I quote, "chronic conditions should serve as a starting point for the restructuring of health care delivery because chronic conditions are now the leading cause of illness, disability, and death in the United States. . . accounting for the majority of health care resources used."

Most Medicare beneficiaries have at least one chronic condition. About a third have four or more conditions, accounting for 80% of all Medicare spending. If we want to stabilize the Medicare trust fund, we must focus on more effective management of the highest-cost conditions. The Institute of Medicine recently identified twenty priority areas for health care quality improvement and included specific interventions for improving care for those with chronic conditions. Priorities listed included care coordination, disease management, end-of-life care, co-morbidity management, interventions for frailty associated with age, medication management, and others. The same priorities are needed as we strengthen Medicare for future generations.

I am fortunate to have a program in my state that offers a model for effective Medicare modernization and that is the Social HMO program. Senior Advantage II, offered by Kaiser Permanente's Northwest Division, is one of four Social HMO demonstrations. Social HMOs have the type of structure needed to respond effectively to chronic illness. The Social HMOs' trademark care coordination and disease management services and expanded benefits directly respond to the IOM priorities for improving health care quality. Further, these benefits and services are offered at no more than Medicare would pay under fee-for-service arrangements. Social HMOs have been shown to improve healthcare for chronically ill seniors by expanding access to primary care prescription drugs and supportive services under modest copayment arrangements; enabling beneficiaries to maintain their independence by avoiding or delaying nursing home placement; decreasing the use of costly services such as emergency room, inpatient hospital and nursing facility services; and improving health outcomes for the frailest beneficiaries.

The Social HMO model also represents an effective strategy for helping address the states' large and growing fiscal crisis. Medicaid is the second largest spending category for state budgets and increased over 13% last year. About 57% of Federal Medicaid increases related to the elderly and disabled. Studies show that Social HMO members are 40 to 50 percent less likely to have long-term nursing home admissions than comparison group members, potentially saving Federal and state governments millions of dollars in Medicaid costs. Preliminary analysis indicates that if the Social HMO program were terminated, and the 110,000 beneficiaries currently served were forced to find alternative coverage, it would cost Medicaid between $100 to $300 million in the first year alone for chronic care services currently covered by the Social HMOs. This figure does not account for the added cost of prescription drugs, vision, hearing and dental care, and other non-Medicare covered benefits provided by the program.

The Social HMO demonstration represents a model for meaningful Medicare modernization. It provides comprehensive coverage of prescription drugs—but it does much more. It provides a benefit, financing and delivery structure to meet the needs of chronically ill seniors—the highest cost, fastest growing subgroup of the Medicare population. For this reason, I have joined with my colleagues from Oregon, Washington, New York, California and Nevada to make this program permanent under Medicare. I encourage this Committee to examine the SHMO as a useful model for

care for the frail elderly—a model which will be increasingly useful as the Baby Boomers—such as myself-age into Medicare.

I thank the Chairman again for holding this important hearing.

PREPARED STATEMENT OF SENATOR ORRIN HATCH

Mr Chairman, I appreciate your holding this hearing today—we have a very distinguished group of witnesses before our Committee. I especially want to send a warm welcome to Dr. Douglas Holtz-Eakin, the new Director of the Congressional Budget Office.

Dr. Holtz-Eakin, I look forward to working with you on this and many other important issues.

Mr. Chairman, I'll be brief. I realize that this hearing is focusing on the overall Medicare program but I want to take this opportunity to talk about Medicare prescription drug coverage.

I think most of us in Congress believe that we must pass a Medicare prescription drug benefit this year. Medicare beneficiaries cannot afford to wait any longer.

Last July, we debated this important issue on the floor of the Senate for close to three weeks. In the end, due to partisan politics, Medicare beneficiaries came up on the short end of the stick because we were not able to pass a Medicare prescription benefit.

As one of the original authors of the Senate Tripartisan Medicare proposal which was considered on the Senate floor during that time, I was extremely disappointed in last year's outcome.

This Congress, the President has said in no uncertain terms that providing a prescription drug benefit to Medicare beneficiaries is one of his top priorities.

That is good news for beneficiaries across the country. However, there is a lot of work to be done before such legislation can be passed by the Congress and signed into law by the President. I believe much of that work will fall on the shoulders of the United States Senate.

I am dedicated to passing a Medicare prescription drug benefit this year. However, in order for this to become a reality, I believe the following must happen: first, the Medicare prescription drug legislation must have bipartisan support. Second, any Medicare prescription drug legislation must include an optional benefit package that would resemble private health insurance.

Third, if a beneficiary wants to remain in traditional Medicare, he or she must be allowed to do so. Fourth, this benefit must be affordable to both beneficiaries and the federal government. Finally, and most important, a drug benefit must be offered to all Medicare beneficiaries, regardless of whether they choose to remain in traditional Medicare or opt for a new, enhanced Medicare plan.

In conclusion, I am hopeful that this year's debate on Medicare prescription drugs legislation will be different from last year's debate. I am dedicated to the passage of this important legislation so Medicare beneficiaries may have drug coverage once and for all. I know that there are many of my colleagues who feel the same way and that is why I believe that it is possible that such legislation will be signed into law this year.

But I believe this needs to be a thoughtful process so, in the end, we provide a drug benefit to seniors that is affordable to the federal government.

Mr. Chairman, I look forward to listening to our witnesses and thank you, again, for holding such an important hearing.

The CHAIRMAN. Thank you. Then let us turn to questions, and we will adhere to the 5-minute rule.

Administrator Scully, you gave us the statistics of the increases that are occurring out there in all aspects of health care and all forms of delivery systems. You spent the last 2 years battling Medicare regulatory complexity. You have made progress in all of the obstacles that are out there.

Can you describe for us ways in which the President's proposed alternative choices, and especially the Federal employees' style Medicare program, would reduce bureaucratic and regulatory complexity? Part of the problem we have with physicians turning away is they can't do the paperwork or they find themselves at risk when they do do it. Please.

Mr. SCULLY. Mr. Chairman, any time you run a $275 billion Medicare program, or my whole agency's budget, believe it or not, if you count both halves of Medicaid, is about $570 billion this year, you are going to—by its nature, to avoid fraud and other things, you have to have a pretty tight oversight and require a lot of paperwork.

But I think one of my greatest frustrations with the program, and I am a big fan of the Medicare program, as I said, "It is a fabulous safety net program" and the reason seniors love it is that they are all covered, heavily subsidized coverage, but the biggest problem that I have with it is that it basically doesn't foster any kind of dynamic change or improvement in the system because, basically, when you are running a hospital, and I used to run a hospital association, 50 percent of your revenues generally come from Medicare and Medicaid.

When every hospital in, say, just to pick Washington, DC, when you pay Georgetown, George Washington, Sibley, and Howard exactly the same amount for a hip replacement with no information on who does the best hip replacement, you are not going to get a lot of dynamic change in the system to get people to go out and figure out who does the best hip replacements and the best heart bypasses.

But when you are fixing prices like that, which we do—my agency fundamentally spends most of its time trying to figure out what the right price is to fix for family physicians in Anchorage or hospitals in Portland, and I think that that is the way the program has always been run, but I don't think in the long run for seniors—you know, one of the things that I have tried to do with the program—it is a big agency. I think our staff does a great job. But they have a job basically that is to regulate a big program and fix prices.

The two things I have tried to do more than anything else is to open up the agency so that people understand more transparently what we are doing on the outside, whether they are physicians or the AARP or provider groups, and also to give patients a lot more information on nursing home quality, on home health quality, on hospital quality, because I really think that if we give people more information, they wouldn't be very happy to find out it is not the way it works in the Federal Employee Health Benefits Plan.

If a senior said—when you tell most seniors, you tell me that I have got to pay exactly the same amount for a really bad nursing home versus a good nursing home from the government, or the same amount for a really good hospital that does the best bypasses in town versus a really bad hospital, and the answer is yes. I think the more you give people flexibility to drive better behavior in the health care system with Federal dollars and more information, the better you are going to improve the system.

One of the reasons I think the Federal Employee Health Benefits system works better, we have no vision that Medicare is going to dramatically change. This is a very slow change over many years. Most seniors are going to stay in Medicare probably long after I am gone, long after I am alive probably, and it is going to change slowly.

But if you are trying to change Medicare, and we believe that giving some seniors the type of ability to go buy a Blue Cross plan that is going to pay differentially for quality and look at it and give consumers more information, it is going to slowly drive change and improvements and make Medicare a more dynamic, responsive program. It is a wonderful program because it covers everybody and it provides security, safety, and very heavy subsidies for low-income people, which is wonderful. But it is very inflexible and it is a very unwieldy insurance product.

The CHAIRMAN. Something that the administration, I, and I think our ranking member, John Breaux, agree on, and he has just come into the room and we welcome him, is something that you might express: the reasons why the administration and you believe it is important to link prescription drug legislation with accompanying Medicare structural reform, rather than doing just a drug benefit program.

Mr. SCULLY. We spent many months on this and the President was incredibly involved, as some of you know, in the details. But I think we tried to look at it with an open mind and I think I started off fundamentally thinking about how we could bridge the gap in the Medicare Commission 2 years ago, so we started looking at it, No. 1, about why did we not get a consensus in the Medicare Commission 2 years ago which Senator Breaux was on. We got ten votes instead of the 11 needed to make a recommendation on a bipartisan basis to Congress. I think we started, Mark McClellan, who now runs FDA, and me and other staff people a year ago, saying what are the major hurdles to get over.

I think one of the notable things about the President's plan is it does not raise the retirement age from 65 to 67, which was a big hurdle from the Medicare Commission, something that may be the right thing to do, but we didn't take it on.

It also did not put in a premium support model. A lot of people were concerned that if you push people into private health plans or HMOs and made them compete with traditional Medicare, you drive up the costs of the old Medicare program. We very consciously did not do that. Those are the two major issues that avoided the 11th vote to get a consensus to make a recommendation to Congress.

So we started off there, and then I think we also started looking at how do you make the private choices work better. People don't really want HMOs necessarily. They are wonderful in some areas, but in many areas—they are great in Oregon and they are great in California. They are not particularly popular in Philadelphia, which is where I'm from, or Milwaukee.

Trying to give people more flexible choices that they have shown they want in the market is where we went. That's why we kind of looked at the Federal Employee Health Benefits model. We also looked at Tricare. But more importantly, trying to give seniors a prescription drug benefit that's going to work, there is no model to do that in a government price-fixed model.

Having my staff and I try to go out like we do for hospitals and doctors and figure out what the government is going to pay for Celebrex and Vioxx and Nexium would be a nightmare. The model that works is the model that we all have as Federal employees,

which is to buy a Blue Cross plan or a CIGNA plan and have them subcontract with Express Scrips or PCS and let them go out and put together the formularies and negotiate the prices to try to drive the right prices and the right volume in drugs.

So we looked at how are you going to efficiently spend $400 billion and give seniors a drug benefit. There is not an easy model out there to tack that kind of system on top of the old existing Medicare program. It is much—if you look at what actually exists in nature now, the thing that works most efficiently is private Blue Cross and other plans providing a drug benefit as part of an integrated overall health care package, and that's how FEHBP works, it is how Tricare works, it is how most of the models that work—and we are determined to try to give seniors access to drugs in all models, but one of the major reasons we got to this point was that we thought the FEHBP model, and we are not exactly designed like that, but it is kind of a hybrid of that, is the easiest way to give seniors access to an integrated plan that is not managed care that would also provide prescription drugs.

The CHAIRMAN. Tom, thank you very much.

We have been joined by our ranking member, John Breaux. John, you can make comments now or——

Senator Breaux. I got here late. Why don't you go on.

The CHAIRMAN. All right. That is fair and appropriate. Let me turn now to my colleague from Oregon, Ron Wyden. Senator.

Senator WYDEN. Thank you, Mr. Chairman and Senator Breaux, as well. Tom Scully has a long history of being willing to reach out and try creative approaches, the Oregon health plan just being one of them.

Let me start with one that I have been looking at as a way to perhaps break the gridlock on this payment equalization issue, which is so frustrating. I think it goes to some of what the senior Senator from Alaska and others have said.

Oregon seniors and providers are frustrated with Medicare because it is, of course, a national program. However, the inequities in the payment mean so often, people in Oregon in Medicare+Choice Plans don't get the benefit they hear other seniors have in other parts of the country. Seniors, because they hear about things that are available under Medicare in Florida and New York because of the huge disparity in payments. Payments to my State's providers in the aggregate are far lower than other States' providers.

Just one example would be DSH. We get significantly less for DSH than a State like New York does. At the same time, our stay in the hospitals is far shorter and far shorter than the average nationally.

What would you think, Administrator Scully, about the idea of our taking a fresh look at this payment equalization issue and look to something I have called tentatively in my mind as an efficiency bonus, so that in the kind of example I gave for our State, where our payments are lower but we also have shown demonstrably something that you can prove at HCFA that we have shorter hospital stays, we might look at a way to try to reward that. Is that something that you would be willing to explore?

Mr. SCULLY. I am not sure, but I think probably, among others, Senator Grassley makes some of exactly the same points about Iowa as I am sure Senator Craig would about Idaho.

The CHAIRMAN. We will make them about Idaho, but it is true.

Mr. SCULLY. We would be happy to look at it. Secretary Thompson, obviously being from a relatively rural State, shares a lot of those views, and we try to look at the existing regulations any way we can to try to look at these geographic inequities, but a lot of it is statutory. Obviously, in the process of going through this year, a lot of these formulas are 15, 20 years old and probably need to be revisited and we would certainly support looking at all of them.

Senator WYDEN. Let us talk about it differently than we have in the past. In the past, what you have had is Senators from Iowa and Oregon and Idaho talk to you about, my goodness, we are getting a raw deal, and everybody then starts jockeying. I think what we need to try to say is let us look at linking it to efficiency, and if a State can show, as I just said in this DSH example, that our lower payments are a problem, but we also can show you that we are lower in cost, because we have shorter hospital stays. I think we have got a shot at breaking the gridlock here.

Mr. SCULLY. If I can just make two cautionary notes. One is that the Medicare program, as I said, is already growing 8.5 percent a year, faster than anybody expected in the last couple years. So if it is a matter of redistributing, because I think there are parts of the country who certainly I wouldn't identify right now, who are probably over-subsidized, if we just spent more in certain areas, that is probably—you have to look, I think, across at it, which makes it painful politically.

The other thing I would caution is that the last time we made a big adjustment effort, which was the right thing to do in 1997, it has basically, in my opinion, destroyed the Medicare+Choice program, which I think is a pretty good program. In 1997, if I can digress for 2 minutes, with the best of intentions, in some States, per capita spending, for instance, in Oregon, I would guess, is about $5,000 a year and in Louisiana it is $9,000 a year and in Pennsylvania it is probably $8,000. What happened in 1997 was Medicare+Choice, which was managed care, was very popular in a lot of urban areas. A lot of rural members from smaller States said, "We want our fair share, too, and because we get underpaid per capita, we ought to disengage the HMO process for the fee-for-service process."

So the problem is, if you are in an efficient State, Minnesota, Oregon, Washington State, Idaho, low-cost States, they said, "It is unfair that we are getting paid 95 percent of our fee-for-service because we have very efficient providers, so we ought to be paid more."

What we did was we went to the New Yorks and the Philadelphias and the Pittsburghs that are very high cost and said, to pay for the—raise the rates of the rural areas, we are going to freeze the urban areas, and my concern is what we did is that we capped it for all the places where those plans are popular—Miami, New York, Philadelphia, Pittsburgh—we capped them at 2 percent growth for 5 years and we strangled them.

So in all these low-income areas where these managed care plans are very popular, we basically killed them.

Senator WYDEN. Let me, if I might get one more question in. If we continue to reward inefficiency, which is the policy today, I think it is going to make it hard to deal with this demographic tsunami. The points you are making are very valid. I want to work with you on it.

The last question I had, just in the time that remains, is that the centerpiece of the administration's Medicare reform is more private choices, more private choices and more competition. I have told you that I am open to this kind of thing as long as it is within the Medicare program and there are tough consumer protections. I was able to write that in the Medigap law.

I would like you to tell us, what are your thoughts about how you would actually enforce tough consumer protections, tough oversight in the ideas that the President is advancing in terms of more private choices, because that is sort of the show-stopper issue. I don't think there is a real shot at a bipartisan compromise, and I am interested in one—I would like to see us get there—until we see exactly how you are going to enforce tough consumer protections under your vision of the Medicare future.

Mr. SCULLY. I think we are highly sensitive to the fact that if you are going to give seniors more choices, you have to have much tougher consumer forces than even in the Medigap, and one of the things that is in our plan is actually to reform Medigap, modernize it and probably have more oversight and more and better plans.

But the vision we have is to split the country up into ten regions. We are happy to do that any way we would like. Tricare has 12 regions. We think it is a better way to—the basic concept is that if you want to—that if you would like to sell a plan, much like an FEHBP in Portland, you have to take all of Oregon, all of Idaho, and all of Washington. That is the Region 10 for CMS. So everybody in the smallest town would have to get the same plan at the same rate.

We would only have three bidders that would prevail in each of those regions, and I have talked to most of the major insurance companies and under this format, they believe that we would have aggressive bidding. We think that would drive lower prices. We think we would have a relatively small handful of plans to oversee, and I think we would have a very interactive—you can imagine if you only had three private PPO plans in the Northwest, in those three States, that were participating, which is far less than we have in Medigap, you would have a pretty active and interactive, I would say, "Role with the Federal Government as the overseer and the plan that are providing it."

For instance, right now in the Federal Employee Health Benefits Plan, a little over 50 percent of the people in that plan are in the Blue Cross plan, and I would—we envision as a much more active oversight role than OPM has with the Federal Employee Health Benefits Plan. We are very sensitive to the fact that if you are going to give seniors more options, and by the way, they would be required to get exactly the same benefits they have under existing Medicare, that we obviously envision very active engagement with

the Federal Government as an overseer than clearly at least our model sees it under the existing Medicare program.

The CHAIRMAN. Ron, thank you very much, and let me turn to our colleague, Senator Kohl. Herb.

Senator KOHL. Thank you very much, Senator Craig.

Mr. Scully, I just would like to ask you as an add-on to what Senator Wyden said, I know you are always a person who looks for solutions to honest problems, and with respect to this inequity, it is well and good and accurate for you to say that we just cannot pay out more without getting something back for it, but it is not really fair to say that, either, because then you just, in a sense, perpetuate what is admittedly an unfair system.

So are there some constructive thoughts and hopes that you can give those of us who are in those States where the inequities exist about the things that you may be doing to address those inequities, or are you—I know you don't want to do this, but are you simply saying, "Well, it is too bad?" What can we look to by way of hope from this administration to address the inequity problem?

Mr. SCULLY. Well, within our ability within our statutes, we have been looking at lots of things, and I would say that if you look at the regulations in the last, like I happen to believe and I think the Secretary believes that as a general measure, probably rural areas tend to get for a lot of these formulas the short end of the stick, and I think if you look at the hospital outpatient rule last year where we made all the adjustments we could, where rural reimbursement went up about 8.5 percent and urban went up about 1.5, all across the board, we have had flux in the way we have looked at it.

It sounds boring, but, for instance, in the hospital wage index, which affects $94 billion a year payment, if you went and looked at the Wisconsin facilities versus New York or Pittsburgh, the No. 1 variable is a—it sounds like a mundane thing called the hospital wage index. We are looking at how to fix that and adjust it to make it fair, but obviously, any time you make fixes that might help a rural area, they have an impact in Philadelphia, where I am from, or someplace else.

But if it is the right thing to do, we have been looking at fixing them and we are having a very thorough review, for instance, of the hospital wage index and how that is calculated right now. That probably will move more money around in the country in the Medicare program than any other adjustment, and it has been done the same way for 25 years and that is not always the way it necessarily should be done and we are going to have a third debate about it in the hospital rule.

The physician payment system, which is a little more equitable, believe it or not, is done a little differently based on geographic variations, is a little fairer and results in somewhat fewer variations and we are looking at that, as well. It may sound mundane, but I think we are looking at all the underlying causes.

I would also say that if you are looking at geographic variations, the way that the President's plan works where everybody would get paid the same amount—every plan would get the same amount, for instance, Wisconsin is in the same geographic area under our guide, and we are willing to look at anything, as Ohio, Indiana,

Illinois, Michigan, Wisconsin, and Minnesota are in one region and they would all be under one plan, and three plans would pay the same amount every place. So that alone would have a huge geographic blending all across the Midwest and reduce a lot of the inequitable barriers in payment and reimbursement all across the Midwest because you would be basically blending all the payments from Wisconsin across all those other large industrial Midwestern States.

In the traditional Medicare program, there are a lot of things we are looking at, but I also think in a reformed Medicare program, there are a lot of ways to make some of the geographic disparities that are built into the program a little fairer, and Senator Wyden very accurately pointed out, one of the problems is if you are in Minnesota, or Oregon, or Washington or a low-cost State, you get in this kind of spiral where, congratulations, you are low-cost so you keep getting reimbursed at low costs. The same thing happens in Iowa and you just keep spiraling down, where if you are in a high-cost State, you keep getting reimbursed more and it keeps going up.

I'm not sure there's an easy way to fix that other than to go back and tinker with the formulas, which we are looking at doing to make them fairer.

Senator KOHL. OK. Thanks.

The CHAIRMAN. Thank you very much, Senator.

Now let me turn to our other colleague from Oregon, Senator Smith. Gordon.

Senator SMITH. Thank you, Mr. Chairman, and Tom, good to see you, appreciate your being here. I mentioned before my interest in the social HMOs. These are currently enjoyed in Oregon, California, Nevada, and New York, and they actually save a lot of money, and their clients prefer SMHOs but the States have a considerable state in SHMOs. Given the crisis in State budgets, we need to think about how SHMOs can actually save money for states by keeping frail elderly out of nursing homes.

I understand you appreciate the value of the SHMOs, as they are called. I along with some others are trying to get them reauthorized. Their authorization is about to run out and I wonder if you can speak to the prospects for SHMOs and whether they will be allowed to continue or if there is something the Federal Government can do to maintain them through this State budget crisis.

Mr. SCULLY. I have spent a lot of time looking at SHMOs and philosophically, I like them. They are different every place. There are a number of different—they are demonstration programs that theoretically run out the end of this year. I think I have already told them that I am planning to extend them administratively, which I can for another year. I think it certainly would be helpful to have Congress look at it and I would love to work with you to fine-tune them.

Some of them are great. As you probably know, the GAO did a report on SHMOs and my staff has done a number of its own reports, and to be honest, they are a little skeptical about some of the SHMOs because they do cost about 10 percent more and some places they have done exactly what they expect to do. But in other places, it has not turned out, and I will just point out—I won't pick

on any company, but, for instance, in Las Vegas, where the biggest one operates, essentially the company that does that has turned their entire Medicare+Choice plan into a SHMO and they get 10 percent more reimbursement and it really hasn't worked out the way it was intended.

So I think from the purely technical side of the staff, they think there are some flaws in some places where it has been taken advantage of.

I personally think for the SHMO program, while they have some flaws here and there, it is greatly liked by the people in it. I think that the structure of the Medicare+Choice plan has pushed a lot of people out of these plans that would like to stay in them, and so at least for now, I am all for keeping the SHMOs as they are and extending them, but I do think that they can use some fine tuning and there have been some places where it has been abused a little bit. Oregon is not one of them, by the way.

Senator SMITH. I know. I have only heard good things, and where there are problems, if you have ideas that you would like us to include in the legislation, I would love to hear it because we want to make them work. The truth is, if these close everywhere, I have estimates that an additional $100 to $300 million in the first year alone will be added to the cost when these people are pushed into nursing homes, where a majority of costs are funded by Medicaid. So we are not helping the States. We are not helping the Federal Government. We are reducing no costs. We are just taking away an option and simply making everybody miserable. So if you can help us to further craft this legislation and extend these SHMOs.

Mr. SCULLY. I would be happy to.

Senator SMITH. I think it is really important, because I think it gives seniors a less expensive and more enjoyable choice.

Mr. SCULLY. I would be happy to come up and go through the details with you. I think in the places where it has worked as intended, it has worked out great. The concern my staff has, in looking at other places where the financing mechanism has been used to basically do non-SHMO patients, it has actually cost the government more and I think we can get the best of both. But I would be more than happy to come go through it with you.

Senator SMITH. Thank you, sir.

Mr. SCULLY. Thanks.

The CHAIRMAN. Gordon, thank you.

We have been joined by our colleague, Orrin Hatch. Before I turn to you, Orrin, though, let me go to our ranking member who arrived just a few minutes ago for comments and questions. We are going to have to, for the sake of our next panelist, this will be the last round we can do, I think, with Tom, so please proceed.

Senator BREAUX. Thank you, Mr. Chairman. It is sort of like a mini-Finance Committee here, and I think the subject is no less important than the subjects we deal with in this area at the Finance Committee.

Tom, thank you very much. I had the privilege of speaking this morning to your old employers, the Federation of American Hospitals, and they asked me to convey a message to you, but I can't do that in this forum. [Laughter.]

Mr. SCULLY. They are much happier since I left, probably.

The CHAIRMAN. If we ask the court reporter not to record it and folks to put their hands over their ears?

Senator BREAUX. It has something to do with not enough, not enough, not enough. [Laughter.]

Mr. SCULLY. They used to say that when I worked for them, I think. [Laughter.]

Senator BREAUX. I have got three points that I would like you to respond to as briefly as you can. The three points against the proposed new Medicare reform system with prescription drugs, as I understand it, are, first, you will force seniors into HMOs. We are patterning the new reform after the Federal Employee Health Benefits Plan. The point I answer in response to the fact that we are forcing seniors in HMOs is I am not in an HMO. I have prescription drug coverage. I have hospital coverage. I have doctor coverage. My choice is Blue Cross-Blue Shield, which is a preferred provider program. You can have an HMO if you choose to, but you don't have to.

Under the President's proposal, is that essentially correct, or can you elaborate on that answer?

Mr. SCULLY. That is exactly—I mean, we have no intention—in fact, it is the opposite. We have no desire to push them in HMOs and I think the realization we have is that most people don't like HMOs. They are great for some people, but as I said, "In the commercial markets for people under 65, we have 70 percent of people in PPO kind of hybrid fee-for-service plans, about 25 percent of people in HMOs, and about 5 percent of people in fee-for-service, and the PPO kind of private fee-for-service option has been exploding, and so we are just trying to provide that option."

Senator BREAUX. So the full coverage of a Medicare recipient under the new proposed plan under enhanced Medicare, they would have full array of health benefits without having to go to an HMO if they decide something else is better for them?

Mr. SCULLY. They could go to any doctor or hospital they wished, yes.

Senator BREAUX. The second is that, well, there is a problem, and it is a legitimate concern from our colleagues who represent rural areas. Obviously, Louisiana has a lot of rural areas and some of our members, their State is almost all rural and they say, "Look, that is fine if you are in Philadelphia, or New Orleans, or Miami, but it is not going to work in a rural county."

My response to that is you pick the most rural county in America and there has got to be at least one Federal employee in that rural county. Maybe he or she works for the Fish and Wildlife Service or USDA as a cattle inspector or what have you, in that most rural county who is a Federal employee who is in the FEHBP, Federal insurance program, that that person has health insurance. They may not have a choice of ten different providers because there may only be one provider. But if there is only one provider, that Federal employee, in essence, is in a fee-for-service plan. Is that not the same concept that we have under the new enhanced Medicare proposal?

Mr. SCULLY. That is exactly why we designed it that way and exactly what I would have said. That is exactly the way it works and precisely the reason we designed it that way.

Senator BREAUX. So that Federal employee in rural county USA that works for the Fish and Wildlife Service, when they go to their doctor, if there is one in the county, or the community hospital or get their drugs filled at a local drug store, maybe the only one in the county, the reimbursement that we pay for as a Federal insurance program is basically a fee-for-service type of program.

Mr. SCULLY. Absolutely, and most of these plans, as I said, the 51 percent of the Federal employees are in a Blue Cross plan, and once you get outside of a big city, it is almost always fee-for-service and that is just the way it works.

Senator BREAUX. That would be available for Medicare recipients in these rural areas?

Mr. SCULLY. At least three different plans that offer that type of exact fee-for-service reimbursement in rural areas.

Senator BREAUX. OK. The final point is that some would argue that, well, I may consider this as long as the prescription drugs that are available for people who want to stay in the whole Medicare program is exactly the same as what we are offering in the new program. My point is that you can't do that if you want to give people choice. If there is no difference, there is, in fact, no choice.

The fact that we are somehow giving people who stay in fee-for-service much less because we are giving them only a discount card which would, hopefully, get the discount down 10, 25 percent, and we are giving them 100 percent coverage after they reach a certain catastrophic level, which is yet to be determined, the government would pay 100 percent after that, plus the discount card, I point out that we have given them both of those extra benefits on the fee-for-service, an old system, without any additional premium charge.

I mean, those things have to be looked at in the context that we are giving them a discount card plus catastrophic prescription drug coverage and there is no projected increase in the premium that is being recommended, for the same exact premium. Then for the people who want to go into the new system, the enhanced Medicare, which would be an integrated prescription drug program, that they may well be paying more for it. But you still have a difference. You have one program that may be a little bit better, but you are paying a little bit more, whereas if you stay in fee-for-service, you are getting a discount card plus catastrophic coverage, but not a single dollar of extra premium charge. Is that essentially correct?

Mr. SCULLY. That is exactly correct, precisely, and there are a couple of reasons that we did that, two very different reasons of many reasons. One is that there was no really easy way, as I mentioned earlier, to design a drug benefit that adds on to the old Medicare program because it doesn't exist in nature. It is much easier to design one that works like your Federal Employee Health Benefits one, that is integrated into an entire kind of Blue Cross package. So it was easier and more rational to design it that way.

No. 2 is, to get enough people into the new enhanced fee-for-service, to make the competitive dynamics enough to save money and drive the competition, you have to get some large enough number of people into that to actually drive the competitive bidding and get the price efficiencies that we are looking for, and so that is the second reason why we did it.

But there are really two reasons that we got to that conclusion. One was the design of the drug benefit.

Senator BREAUX. I thank you for your responses and I will bring back the message to the Federated Hospitals that you said hello.

Mr. SCULLY. They don't want me back, huh? [Laughter.]

Senator BREAUX. Thank you.

The CHAIRMAN. You are also a pretty good straight man for the administration's program proposal.

Senator BREAUX. It is really mine——

The CHAIRMAN. I know that.

Mr. SCULLY. We stole his ideas.

The CHAIRMAN. The art of plagiarism. We love it around here. [Laughter.]

Anyway, thank you very much.

Let me turn to my colleague from Utah, Orrin Hatch.

Senator HATCH. I am glad you are stealing some of his ideas.

Mr. Scully, I was wondering if you could share with the committee members any data that the administration may have on the differences of provider reimbursement rates for the Federal Employee Health Plan and the Medicare program, and if not, do you know if such data is even available?

Mr. SCULLY. I have a fairly significant amount of data on it that varies massively, some higher, some lower. The FEHBP tracks some of the better private sector health plans, and in some cases, it depends on the State, it is lower. In some cases, it is higher. But I would be happy to give you a lot for Utah, if you would like, or other States.

Senator HATCH. That would be great. The President's framework—I will just have my staff get with you and we will get what we need. The President's framework is based on a new option called preferred provider organizations, and I think that is an attractive idea for beneficiaries. It is my understanding that the administration relied heavily on the demonstration projects involving PPOs. Am I right about that?

Mr. SCULLY. Well, we thought it was a good start, but there are some fundamental structural differences that we think the new plan will work a lot better because it will be better financed.

Senator HATCH. What evidence do you have that you can replicate these PPOs across the country if more than 90 percent of the people in the demonstrations were in a county with Medicare+Choice enrollment and payment rates in excess for what fee-for-service will pay? One thing I am concerned about is a little bit like the senior Senator from Louisiana. How is this going to work in a rural State like Utah, where we don't have any Medicare+Choice plans?

Mr. SCULLY. It is totally different, Senator, from Medicare+Choice. Medicare+Choice is basically you have to have an HMO. You have to be able to deliver an HMO. There are no networks. In most rural counties in Utah, there is one hospital and probably a small doctor group and there is no way to put together an HMO. So even though the rates have been massively escalating in the last 10 years on the theory that that would draw private plans out into the rural areas, no one has shown up generally because there is no way to put together an HMO.

On the other hand, PPOs exist all over the country in all types of rural areas, and as Senator Breaux has mentioned, a postal worker or a forest ranger in Montana or in Utah can get one of the most rural areas.

The fundamental structural difference is that we are not trying to draw HMOs, but the other issue is if you want to offer a health plan in Utah right now, you pick your counties and there are constructs, and I am trying to remember which region Utah is in, but I believe it is in the Rocky Mountain Region. If you are Blue Cross or CIGNA, you would have to offer a plan to everybody in Utah. So to sell in Salt Lake City, you would have to sell the identical plan for the same price all through the State, all through Colorado, Wyoming, Montana, the whole mountain region. That would be the same plan at the same price with the same premium.

So, essentially, what the insurers, and we found this through FEHBP and through Tricare, is that the bulk of the people they get in the urban areas just—they are required to provide the same level of service in a fee-for-service context in rural areas. So if you are in rural Utah, you wouldn't be in managed care. You would effectively be in a fee-for-service benefit package.

Senator HATCH. As you know, the structure isn't in place in Utah, and I think probably in many other places throughout the country, and I just wonder what it is going to cost to put that into effect.

Mr. SCULLY. I would argue that for Federal employees, and this basically mimics FEHBP and for Tricare, which is the Defense dependents program, it works very well. Effectively, you are in a rural area of Utah as either a Federal employee or a military person, you go to any doctor you want, and you are already in essentially their Blue Cross or CIGNA plan, and I think it will work exactly that way.

It is definitely not intended to be HMOs. We totally are aware that there are no HMOs in almost any rural area once you get outside of large cities.

Senator HATCH. Do you have any idea how much something like that is going to cost?

Mr. SCULLY. Our actuaries, who, I am proud to say, are extremely independent and generally are perceived in the government as being totally nonpartisan and kind of the most trusted people in health care scoring—CBO's are, as well, but I think generally, more than most agencies, our actuaries have been perceived to be very independent, they believe that the competitive bidding process for these ten regions would be able to offer the same benefit package for Medicare through competitive bidding for a slightly lower price and a slightly lower premium than commercial Medicare, and we did not come up with a detailed plan. Obviously, we read lots and lots and lots of options before we came up with our framework.

We have had our actuaries up talking to people in Congress and I think their very highly regarded judgment is that the cost of this would be slightly less than the competing premium for the identical benefits of Medicare.

Senator HATCH. Mr. Chairman, my time is almost up, but I am very interested in CBO's opinion, as well, on this because I think

it is an important set of issues. So I hope if I can't be there, that CBO cover that.

Mr. SCULLY. I am not sure CBO agrees. We have been talking about it, but we are in the beginning stages. [Laughter.]

Senator HATCH. OK.

Mr. SCULLY. But I will tell you that I think they would agree, as would most people in health care on the Democratic and Republican side, that the HCFA CMS actuaries are generally perceived to be completely independent. Sometimes that doesn't work out well for me, but I can tell you they are completely independent. [Laughter.]

The CHAIRMAN. Administrator Scully, thank you very much for your willingness to be here today, your openness, your candidness about this. This is one of the big hurdles that we know that this Congress has got to attempt to face, and certainly the administration has led with a proposal. You have not been timid and you shouldn't be. All of these models need to interact. We need to see the different approaches.

There needs to be this kind of discussion and debate before we decide, because what is significant is that the Ron Wydens and the Larry Craigs and the Orrin Hatches and the Gordon Smiths of this world all agree about the problem in general and all agree there needs to be a solution, and that in itself is a major step toward that solution, especially when we begin to narrow it to certain models that we think might fit. I think, clearly, what the administration is doing and what you are doing helps us narrow that playing field significantly.

Senator WYDEN. Mr. Chairman, just for 30 seconds, I want to follow up on my interest in working with you and the Administrator on this point. I think when you talk about Federal employees and making a link, which I am attracted to and have made it myself, there is a difference between a 40-year-old Federal employee who is a Fish and Wildlife employee in rural Utah or rural Oregon and a 75-year-old elderly woman who there was a history, particularly with Medigap until we wrote the law, of people exploiting that person.

I think if we can work together with you to make sure that these choices are inside Medicare and recognize the vulnerability of people and the need for the oversight and the consumer protection so that people won't be ripped off by being part of a modernized Medicare program, I think we can get through it. I am going to follow up with you, Mr. Administrator, on this point and work with you on it and I thank you for that extra time.

Mr. SCULLY. I will be very brief, but I would make one point I hadn't made, which is the fact is there are a couple million people that are Federal Employee Health Benefits retirees who already get Medicare and they wrap around Medicare and to them, they don't know the difference. So there is already pretty substantial evidence that in Medicare alone, this already works. Thanks.

The CHAIRMAN. Thank you, Mr. Administrator. We do appreciate it.

We appreciate also the patience of our next panelist, but we felt it was tremendously important that we get Dr. Douglas Holtz-Eakin——

Senator TALENT. Mr. Chairman, may I trespass on your patience just to ask him one question.

The CHAIRMAN. Yes, please. Please be seated.

Excuse me. We have been joined by Senator Talent, another colleague of ours, a member of this committee, and yes, please do.

Senator TALENT. Mr. Chairman, thank you. Once again, Mr. Chairman, you have scheduled an extremely important and relevant hearing to all of us, especially to Missouri. We have a population that is more elderly than most States. About 14 percent of our people are 65 years old or older.

I am certain that there have been a lot of discussions about funding Medicare for the future. I am not going to ask questions that I imagine have been asked, although we may submit something to you later on in writing.

There is a subject, though, that I want to get into and just get your comment on, because I think it presents a possibility for really improving the quality of the health care that we offer seniors through Medicare while also enabling us to save dollars that we can then direct in treatment, and that is the question of information technology in health care in general, and particularly for Medicare providers.

My sense anecdotally, and I tour a lot and talk a lot to people who are providers in Medicare, hospitals, physicians, et cetera, and I also think the data indicates this pretty clearly, is that health care, for one reason or another, is behind other parts of the economy in information technology. I am not talking about treatment technology, the new CAT scan, the new chemo method. I think we are at a cutting edge there. I am talking about providers getting and sharing information through computers or electronic medical records that will reduce medical errors and permit them to save dollars that now go into keeping hard copy and paper.

An example, I had sinus surgery 3 weeks ago, Mr. Chairman, and the first three people who talked to me took down the same information from me about my history and put it on hard copy. You are going to go into a physician's office and they all have a back room with all this hard copy stuff. When I go to the Jiffy Lube to get my oil changed, I give them a card that they have given me. They put it in a computer and they can see everything that they have done to my car, at least in the Jiffy Lube system.

So what I am saying, and I know providers are out there trying to update these systems, what can we do through Medicare? Could we change some reimbursement formulas and maybe provide a little extra money to encourage them to get this architecture in place with all the promise that it holds for allowing us to invest dollars in what we ought to invest it in, not paperwork and not accumulating things we don't need, but putting it into solid care for seniors? I just want Mr. Scully to comment on it. Thank you for allowing me an extra moment to do that.

The CHAIRMAN. You bet.

Mr. SCULLY. I don't want to push Chairman Craig's patience. I could talk to this for hours. You are completely right. Secretary Thompson is going to have a fairly big announcement about this in Detroit tomorrow. We had about 50 of the leading IT people in meeting with me and the head of ARC on Monday to talk about

this and I think the issue is that health care, and Secretary Thompson's pet project is 20 years behind, and Jiffy Lube is a great example. We are not as good as Jiffy Lube.

Providers want to do it. I think we can really provide some tremendously positive incentives in Medicare and I hope in the process working with the Finance Committee and you this year we can do that, to encourage people to do that. But we are way behind. We are trying to—the main thing the Federal Government can do is put out standards so people are working on the same set of railroad tracks and talk to each other, and we also need creative financial incentives, and I am a big advocate of doing that and I hope I can work with the committees to do it this year.

Senator TALENT. I would be very interested in helping you and the Secretary with that. The potential for this, I think, is much greater than we may know, to improve this system. If there are some problems—some people have said to me, well, the privacy regulations make it difficult to get this in place. I don't know that I totally believe that, but if they need some help here or in your agency to fashion these regulations to permit them to do it, we certainly ought to.

Mr. SCULLY. I would love your help.

Senator TALENT. This is a total up-side.

Mr. SCULLY. You may have noticed the FDA came out with bar coding for drugs the other day. This is Secretary Thompson's, next to bioterrorism, probably favorite subject.

Senator TALENT. I am glad to hear that and I thank you for your indulgence, Mr. Chairman.

The CHAIRMAN. Thank you again, Tom.

Mr. SCULLY. Thanks.

The CHAIRMAN. We do appreciate it.

Now, let me turn to our next witness, Dr. Douglas Holtz-Eakin, who has just last month become our new Director for the Congressional Budget Office. I understand that today's testimony will be his first before Congress since taking office. We are not such a daunting committee. We are really kind of a friendly sort of crew here, Doctor.

Dr. Holtz-Eakin comes to this post most recently from the President's Council on Economic Advisors, where he served as Chief Economist. He is also, needless to say, a distinguished economist and is currently on leave from Syracuse University.

Doctor, we welcome you before the committee. An economist just wouldn't and couldn't be present without a chart, and so I see you haven't disappointed us. Please proceed.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. HOLTZ-EAKIN. Thank you very much, Mr. Chairman. It is a pleasure to have the opportunity to talk about the future of the Medicare program.

Medicare is the Federal Government's largest health care financing program and, with projected outlays of roughly $280 billion this year, the second-largest Federal program overall. It is the principal payer of medical bills for some 40 million elderly and disabled people, with payments per enrollee currently averaging $7,000 a year.

I have prepared a much longer written statement, which I will submit for the record. Here, let me confine myself to a few brief points and then we can take some questions.

If Medicare continues to operate as it is currently structured, its costs will rise significantly, even in the absence of any program initiatives, such as a new prescription drug benefit. In the base case outlined in my written testimony, the Congressional Budget Office (CBO) estimates that Medicare's costs will rise from 2.4 percent of gross domestic product (GDP) today to 9.2 percent in 2075. Another way of looking at this growth is to consider what would happen if it just simply occurred today. If Medicare's program costs today were 9.2 percent of GDP, they would account for one-half of what is now spent on the entire Federal budget.

The program will grow for two reasons, outlined in the chart that I brought along with me so as to fulfill my reputation of being an economist. There are really two drivers in the cost of Medicare. First, is simply the aging society in which we reside. Aging will account for about 30 percent of the increase in Medicare's costs over the next 75 years.

The second major reason for the rising costs of Medicare is simply the excess growth in health costs nationally above the growth rate of GDP, and that contributes the remaining 70 percent. That is the large dark area at the bottom. The aging is simply the 30 percent gray area at the top. Those two will add up to substantial growth, nearly quadrupling the overall costs of Medicare as a fraction of our national economy.

In the absence of any kind of changes in the program, the future growth of Medicare is going to force two broad types of tradeoffs. The first is that if we are to keep Federal receipts, which are currently about 18 percent of national income, at this roughly historical level, the rising costs of Medicare will entail broad tradeoffs within the Federal budget against other programs and initiatives that the Congress may be interested in. The second broad tradeoff would be that if the Congress decided to let the overall level of receipts as a share of national income rise, the costs of Medicare would compete against private uses for those same resources. So the underlying trends that we see in the graph will force two broad tradeoffs in the future as the program continues to grow under current law.

These observations suggest a two-part framework for thinking about the future of Medicare policy. First, ultimately, the costs of Medicare and other forms of future retirement income services as well as the consumption of the working age population will be drawn from the U.S. economy as a whole. The larger the economy

is, the more easily retirement-related costs can be covered without cramping the lifestyles of workers. In that light, it would be useful to structure the overall budget policies and, to the extent possible, increases in Medicare programs to minimize the incentives for people to consume more at the expense of resources for investment in the economy.

Medicare and related Federal entitlement programs are heavily oriented toward consumption, and as their costs rise, they generate pressures at odds with the savings and investment that will constitute the core of economic growth. Program expansions by themselves would only increase the extent to which those pressures impinged on faster economic growth. If major changes to Medicare's benefits are to be undertaken, both their value to program recipients and the strains that will place on the economy must be considered.

Second, regardless of the fraction of the Federal budget and the economy ultimately devoted to Medicare, it will be desirable to utilize Medicare funds as efficiently as possible to purchase the highest-value care per dollar. Medicare beneficiaries, their families, and providers are best positioned to guide the use of additional dollars and to choose those services that meet their therapeutic demands and match their individual tastes. Providing those parties with a broader range of choices and improved information, and ensuring their sensitivity to the costs of these services, should facilitate better decisionmaking. At the same time, an appropriate balance must be struck between providing stronger financial signals to beneficiaries on the costs of their care and also protection against greater financial exposure.

Another point I would like to make is that, as with any long-term projection, the CBO base case is subject to some risks and uncertainty. To pick only one, the rate of excess cost growth in our base case is 1 percent above the growth rate of GDP. If excess cost growth turned out to be even half a percentage point higher, the implication would be that Medicare's costs would rise not to 9.2 percent of GDP but even higher, to 13.2 percent. Alternatively, if excess cost growth was half a percentage point slower, or half a percentage point above the rate of growth of GDP, the rise would only be to 6.4 percent of GDP.

Regardless of which side of that you might come down, on two observations are, I think, in order. The first is that, historically, over roughly the life of the Medicare program, the excess cost growth has been 2.8 percent of GDP, and second, Medicare's costs are going to rise regardless of the band of the uncertainty that you put around them.

My final point is that the aging component will arrive soon. Between the birth of Medicare in roughly 1970 and 2030, the ratio of retirees to workers is going to roughly double, and that aging component argues that moving sooner as opposed to waiting will make any adjustments to the Medicare program easier.

I will close with that and be happy to take your questions.

The CHAIRMAN. Doctor, thank you.

[The prepared statement of Dr. Holtz-Eakin follows:]

CBO TESTIMONY

Statement of
Douglas Holtz-Eakin
Director

The Medicare Challenge: It's Not Just About Prescription Drugs

before the
Special Committee on Aging
United States Senate

March 20, 2003

This statement is embargoed until 10:30 a.m. (EST), Thursday, March 20, 2003. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss the future of the Medicare program with you. Medicare is the federal government's largest health care financing program and, with projected outlays of $277 billion this year, the second largest federal program overall after Social Security. It is the principal payer of medical bills for some 40 million elderly and disabled people, with payments per enrollee currently averaging $7,000 a year.

Because the issues that the Medicare program will soon face are not exclusive to it, they are best understood when evaluated in the context of society's aging, the rising costs of health care generally, and the long-range financial strains that in coming decades will affect the federal government as a whole. If the program continues to operate as it is currently structured, its costs will rise significantly—even in the absence of program expansions such as a prescription drug benefit. As a consequence, Medicare will necessarily compete with other spending priorities for a much greater share of the federal budget or with private-sector spending for a bigger share of the national economy—or with both.

In light of that outlook, any approach to Medicare should incorporate two features: a recognition of the larger economic and budgetary trade-offs, and consideration of the program structure that would best support Medicare's overall objective of providing financing for high-quality medical care for the elderly and disabled. With regard to economic and budgetary trade-offs, two issues stand out. First, to the extent that the U.S. economy grows at a healthy pace, it will be better able to meet the Medicare population's demands for health care. Put differently, the overall level of national income available in the future constitutes the reservoir from which the resources for both private needs and public programs will be drawn, and the nation must endeavor to enlarge that reservoir to the greatest degree possible in making public policy. Second, the potential pressures on the federal budget from Medicare and other sources will necessitate trade-offs with other spending priorities if federal programs are to absorb no more than their historical fraction of national income.

Alternatively, public policy may steer a course toward devoting a larger fraction of the federal budget and the economy as a whole to Medicare. Even if that is so, it will be desirable to utilize those Medicare funds as efficiently as possible—to purchase the highest-value care with each dollar. Medicare beneficiaries (or their families), together with their providers, are best positioned to guide the use of additional dollars and to choose services that meet therapeutic demands and match individual tastes. Providing those parties with a broader range of choices and improved information, and ensuring their sensitivity to the cost of those services, should facilitate better decisionmaking. At the same time, an appropriate balance must be struck

between providing stronger financial signals to beneficiaries about the cost of their care and providing protection against greater financial exposure.

Improved decisionmaking offers the potential for dynamic consequences as well. Technological advances have historically been a big driver of cost growth in health care services. Subjecting health care innovation to the test of whether a new service, device, or procedure is "worth it" in the view of beneficiaries and their doctors may bring improved discipline to the innovation process.

Finally, as a matter of perspective, I would note that Medicare spending constitutes 17 percent of national expenditures for health care. Accordingly, any effort to ensure that Medicare emphasizes obtaining the highest quality of care per dollar of spending will be more effective if it is undertaken in the context of comparable efforts in the health care sector as a whole.

DEMOGRAPHIC TRENDS

The trustees of the Medicare and Social Security programs estimate that the number of people ages 65 and older could more than double over the coming decades, rising from 37 million today to 70 million in 2030 and 82 million in 2050. That increase is part of a great change in the structure of the U.S. population. Looking at the 20-year period ending in 2010, if the current projections hold, the number of workers in the economy will have grown by more than 33 million; yet the number of people ages 65 and older will have grown by only 8.3 million, or roughly one-quarter as much. In contrast, for the subsequent period, 2010 to 2030—when the baby-boom generation will retire—the number of workers is projected to grow by 14.4 million, whereas the population ages 65 and older is expected to grow by 30 million, or about twice as much.

The consequence of those diverging patterns is that the ratio of the population ages 65 and older to the population in its prime working years—people ages 20 to 64—is projected to grow from 21 percent today to 35 percent in 2030 and 42 percent in 2075. In other words, although the shift to an older society starts with the baby boomers, it persists after they have retired, making the changes more than just a temporary bulge.

That projected demographic shift rests heavily on assumptions about longevity, birth rates, immigration, retirement patterns, and other factors. Although based on past trends and recent experience, all of those assumptions are subject to varying degrees

of uncertainty. Major breakthroughs in medical science could further extend life expectancy, immigration could continue its upward track or be curbed by security concerns, and people could choose to work longer or spend more of their advanced years in partial employment. Without question, considerable uncertainty surrounds any 75-year projection.

Nonetheless, a substantial portion of the coming demographic shift is already in place. The post-World War II baby boom and the 1970s "baby trough" are historical events; the subsequent uptick in birth rates has not been substantial and may now have leveled off; and life expectancy continues to increase. Indeed, the Medicare trustees project that life expectancy for the Medicare population will rise by one year for every 15 years in their 75-year projection period.

HEALTH CARE TRENDS

Nationally, health care expenditures as a percentage of gross domestic product (GDP) have more than doubled over the past several decades, growing from 7.0 percent in 1970 to 14.8 percent in 2002. At the federal level, with Medicare and Medicaid in the forefront, health care expenditures have risen from 1.7 percent of GDP in 1970 to 4.7 percent in 2002, and their share of federal outlays has risen from 9 percent to 24 percent.

On a per capita basis, national spending on health care has increased from $1,321 in 1970 (in 2002 dollars) to $5,366 in 2002, or an average of about 4.5 percent per year. The major factor contributing to the growth of real (inflation-adjusted) per capita health care spending has been the development and diffusion of new medical technology. Other factors include expansions in insurance coverage, rising income, medical price inflation in excess of general inflation, and the aging of the population.

In recent years, spending for prescription drugs has grown more rapidly than other health care spending. In real terms, from 1990 to 2002, per capita spending for prescription drugs increased at an average annual rate of about 9 percent, compared with about 3 percent for all other health expenditures. (In contrast, during the 1970-1990 period, spending for prescription drugs grew more slowly than all other health expenditures.) Despite the recent rapid increase in prescription drug spending, it currently accounts for only about 10 percent of all national health expenditures.

In general, new technology changes the pattern of use of medical services, leading to increases in utilization for some services and decreases for others. In other sectors of

the economy, technological advances have often served to reduce costs. On balance, however, research has found that medical innovation has led both to increases in health care expenditures and, frequently, to improvements in the treatment of medical conditions.

With respect to pharmaceuticals, Congressional Budget Office (CBO) analysts continue to monitor the available evidence on the extent to which spending for prescription drugs might be offset by savings in other categories of health care costs (such as hospitals, physicians, and nursing homes). Existing research provides little insight into the overall effect of changes in prescription drug coverage. Several studies have suggested that giving specific drugs to particular classes of patients will reduce their spending for other health services, but it is unclear whether those results can be applied to the general population. More broadly, determining what health care spending would have been in the absence of increased drug use presents substantial methodological challenges.

Whether measured in total or on a per capita basis, both government-financed and private-sector health care costs have grown rapidly over the past 30 years, outpacing the economy's growth rate. Comparing cost growth in the private sector and in the Medicare program can be difficult because of the differences in the populations covered and the benefits provided—particularly as those components change over time; as a result, even well-structured comparisons have shown differing rates of growth for periods of several years. Over the longer term, however, the data show roughly comparable growth rates for total health care costs for Medicare and the private sector (reflecting, in part, past legislative action aimed at bringing Medicare payments in line with market-based rates).

MEDICARE TRENDS

From 1970 to 2002, Medicare costs after adjusting for inflation increased more than eightfold. As a share of GDP, they rose from 0.7 percent in 1970 to 2.4 percent this year. Although cost growth on a per-enrollee basis was volatile, it, too, generally rose by much more than the economy. Over the 1970-2002 period, real costs per enrollee grew at approximately the rate of per capita GDP plus 2.8 percentage points—or at about twice the economy's growth rate.

The major elements in the Medicare program's overall rise in costs have been increased enrollment (from 20 million beneficiaries in 1970 to 40 million this year) and the same factors that have led to increases in health care spending in the nation as a

whole—most notably, the development and diffusion of new medical technology. Other contributors to cost growth have been program expansions as a result of legislative and administrative changes.

In dollar terms, inpatient hospital care accounts for the largest portion of the Medicare program's growth. Expenditures for skilled nursing care and home health services, though constituting only 5 percent each of current program spending, have grown particularly rapidly. Real spending for those services increased at an average annual rate of about 12 percent from 1975 to 2001, compared with an average annual rate of about 7 percent for total Medicare spending.

HOW BIG IS THE PROBLEM?

The convergence of an aging society and rapidly rising health care costs portends a very large long-term escalation of Medicare spending. For more than two decades, the program's trustees have consistently projected long-range financing shortfalls and eventual insolvency of the larger of the two parts of Medicare, the Hospital Insurance (HI) trust fund. In the trustees' latest report, the HI trust fund is projected to be depleted by 2026; over the next 75 years as a whole, the program would need 71 percent more resources than those provided under current law. In the 75th year, it would need over 200 percent more—under current law, its receipts would equal 3.4 percent of taxable payroll while its expenditures would equal 11.2 percent.

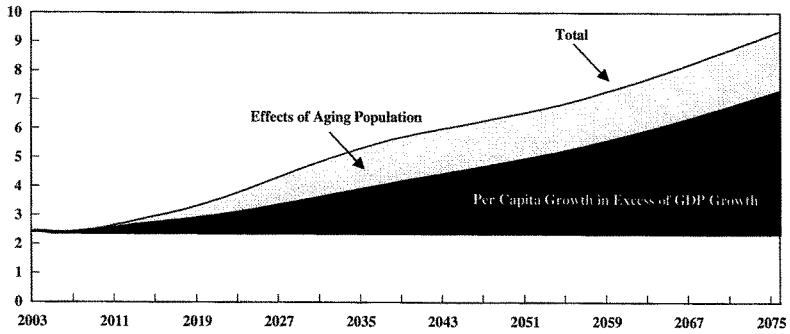
The impact of the demographic shift is clearly illustrated by the trustees' projection of a decreasing number of workers per HI beneficiary. In 1970, there were 4.6 workers for every recipient; today, there are 3.7. The trustees project that in 2030 and 2075, there will be 2.4 and 2.0 workers, respectively, per beneficiary.

Important as these reports are, the trustees' projections and "trust fund accounting" tell only part of the story of the program's impact on federal budgetary resources and the economy in general. Trust funds are bookkeeping devices. As such, the Medicare trust funds provide spending authority for the Treasury Department to make payments, but they do not generate the actual resources needed to make those payments. Much of what is credited to trust fund accounts comes from payments or contributions from the government's general fund—transactions that are simply internal bookkeeping entries by the Treasury.

More important, the trustees' traditional measures of insolvency are not measures of the program's impact on the economy. The best example of that is reflected in the

Figure 1.
Projected Long-Range Growth of Medicare Spending

(As a percentage of GDP)



Source: Congressional Budget Office.

financing of the Supplementary Medical Insurance (SMI) part of Medicare, three-quarters of which comprises general fund contributions that are intended to cover costs not met by enrollees' premiums. Under those financing provisions, it is technically infeasible for SMI to be projected insolvent, despite the fact that its costs are projected to rise from 1 percent of GDP today to 4.2 percent in 2075, a faster rate of growth than that projected for HI.

To put the long-term outlook in a broader economic framework, CBO has projected the cost of Medicare as a share of GDP to show how much of the nation's production of goods and services it estimates will be used to pay for the program. Using its recent baseline budget assumptions for the next 10 years and those of the Medicare trustees for the subsequent long-range period (to 2075) as a base case, CBO estimates that Medicare's costs will rise from 2.4 percent of GDP today to 9.2 percent in 2075 (see Figure 1). Approximately 30 percent of that growth is due to society's aging; the remaining 70 percent is attributable to general growth in health care costs in excess of the rate of GDP growth.

Another way of looking at that growth is to consider it in today's context. If the Medicare program's costs *today* accounted for 9.2 percent of GDP, they would equal

half of what is now spent under the entire federal budget. If the program's higher costs were added to what is now expended, total federal receipts (which currently absorb about 18 percent of GDP) would have to be one-third larger. And if those increased costs were paid for entirely through a payroll-based tax, the rate now set at 15.3 percent on the earnings of most workers would have to more than double—a rise equal to roughly $6,000 per worker (that is, $3,000 each for the worker and his or her employer).

RISKS TO THE OUTLOOK

The most significant aspect of those projections is that annual growth of per capita Medicare spending is expected to increase faster than GDP but less quickly than in the past. CBO's base-case projection assumes that per capita Medicare spending will eventually rise 1 percentage point faster than the growth of GDP—a rate substantially slower than the 2.8 percentage-point "excess cost" rate that the program has experienced over the past 32 years. CBO's assumption of an eventual deceleration in the relative rise of health care costs is consistent with that of the Medicare trustees (as well as others). But that assumption might be too optimistic, and even small variances from it could have significant economic implications when costs are projected over long periods.

For example, if CBO's long-range projection had incorporated an excess-cost rate for Medicare that was 0.5 percentage points faster than was assumed in the base case, Medicare expenditures would be projected to grow to 5.4 percent of GDP in 2030 and 13.2 percent in 2075, compared with the base-case projections of 4.7 percent and 9.2 percent. Alternatively, if the growth rate was pegged to rise by 0.5 percent less than in the base case, Medicare spending would still reach 6.4 percent of GDP in 2075, or more than two and a half times its current share. Both assumptions imply much higher relative costs than those Medicare incurs today, but the spread of nearly 7 percent (of GDP) between the two estimates provides some perspective on the uncertainty surrounding the program's eventual share of the economy.

Adding to that uncertainty is the potential for program expansions. Enacting a new prescription drug benefit, easing existing limits on payments to providers, and possibly expanding long-term care coverage would exacerbate both the rising long-range spending trajectory and the risks associated with the long-term outlook.

A FRAMEWORK FOR POLICY ANALYSIS

Ultimately, the costs of Medicare, other forms of future retirement income and services, and consumption for the working-age population will be drawn from the economy. The larger it is, the more easily retirement-related costs can be covered without cramping the lifestyles of workers. In that light, it would be beneficial to structure policies, to the extent possible, to minimize incentives for people to consume more at the expense of resources for investment. Medicare and related federal entitlement programs are heavily oriented toward consumption, and as their costs rise, they generate pressures at odds with the savings and investment that constitute the core of economic growth. Program expansions by themselves would only increase the extent to which those pressures impinged on faster economic growth. If major changes to Medicare's benefits are to be undertaken, both their value to program recipients and the strains they will place on the economy must be considered.

The most effective approaches to constraining Medicare costs in the future—and to getting the greatest improvement in health for the money that is spent—are likely to be those that give beneficiaries and health care providers appropriate incentives to spend federal funds wisely. In particular, beneficiaries should have as many choices among providers and health plans as are feasible, but they should also be aware of and be sensitive to the consequences of those choices. Because Medicare—for all its massive size—constitutes only about 17 percent of national outlays for health care, efforts to improve its efficiency would stand a greater chance of success if they were generally consistent with the directions being taken in the larger health care system.

POLICY OPTIONS: THE FUNDAMENTAL CHOICES ARE DIFFICULT

Medicare is a popular program, so options to relieve these long-term fiscal pressures require difficult choices. Garnering public support to cut or constrain the program's growth is difficult. Even in the face of the long-term fiscal strains described here, the momentum of late has been for program expansion. Taxes could be boosted, but doing so could impair economic growth, and if taxes were the sole means used to pay for Medicare, the resulting increase would be large.

CBO has estimated the long-term impact of two measures to constrain the program's growth (see Table 1). Gradually raising Medicare's eligibility age from 65 to 70 would adjust the program to reflect past and projected increases in longevity. On the basis of average longevity at the time, new retirees in 1970 could expect 16 years of

Table 1.
Effects of Illustrative Options for Reducing Growth of Net Medicare Spending

(As a percentage of GDP)	2002	2030	2050	2075
Raise the Eligibility Age to 70	n.a.	-0.2	-0.6	-0.7
Collect 50 Percent of SMI Costs from Enrollees	n.a.	-0.6	-0.7	-1.0
Memorandum:				
Projected Gross Medicare Spending Under Current Policies	2.4	4.7	6.5	9.2
Less: SMI Premiums	0.2	0.6	0.7	1.0
Projected Net Medicare Spending Under Current Policies	2.1	4.2	5.8	8.2

Source: Congressional Budget Office based on its January 2003 baseline budget projections and the 2002 report of the Medicare trustees.

Notes: SMI = Supplementary Medical Insurance (Part B of Medicare); n.a. = not applicable.

The effects of each illustrative option are considered in isolation; if implemented together, the options would interact in ways that would reduce the combined savings.

Medicare coverage. Today, new enrollees can expect 18 years of coverage. On the basis of current projections, those enrolling in 2030 will be able to expect nearly 20 years. Such a change in the age of eligibility would constrain the program's long-term spending trajectory and produce savings equal to 0.7 percent of GDP in 2075. Medicare's overall costs would nevertheless climb from 2.4 percent of GDP today to 8.5 percent of GDP in 2075.

Doubling the SMI premium would similarly recognize and adjust for the increase in lifetime benefits as well as return the enrollee's responsibility for that program's financing to its original 50/50 split with the federal government. (Today, enrollees' premiums cover only 25 percent of SMI's costs.) This change would produce program savings equal to 1 percent of GDP in 2075.

Although the options noted above seemingly constitute major reforms of Medicare, they would merely temper the rising program costs now projected. Even if measures were enacted that cut in half the projected rate of excess cost growth in Medicare, the program's eventual share of GDP would still more than double, rising from 2.4 percent today to 6.4 percent in 2075.

Other approaches would raise beneficiaries' cost sharing for services, reduce providers' payments, employ disease management and case management, and introduce greater competition to the Medicare market. For example, one alternative would

limit what Medicare contributes toward health care expenses. A defined contribution could strengthen consumers' and providers' incentives to seek efficient modes of care. Depending on the level of the benefit and the response of consumers, providers, and health plans, such an approach might (but would not necessarily) increase the costs borne by beneficiaries. A related approach would be to stimulate private health plans to compete through premiums to a greater degree than they do under current policies. Such an approach might reduce costs to the extent that it gave beneficiaries suitable encouragement to join efficient health plans and provided structured incentives to induce private plans to negotiate rates with providers that grew more slowly than Medicare's current-law payment rates. However, there is little experience on which to base long-range estimates of the cost savings from introducing competitive approaches to Medicare or to assess their effects on beneficiaries.[1]

CONCLUSION: BETTER TO ACT SOONER RATHER THAN LATER

Without changes to Medicare—and to other federal programs—the aging of the baby-boom generation will cause a substantial deterioration in the fiscal position of the U.S. government. The sooner we begin to address that problem, the better off we will be. Implementing gradual action today avoids the need for precipitous and disruptive action later—which could take the form of either sudden large constraints on benefits or large increases in taxes that depress marginal work effort and incentives to invest. Phasing in program changes allows for gradual accommodation and time to promote alternatives for the recipient population. And it gives time for the public to modify its expectations and for people to adjust their work and saving behavior.

Most important, taking action now to moderate the long-range spending pressures would lessen the risks of large tax increases or unsustainable borrowing and thus enhance the economic prospects of future generations. Of course, reducing the growth of benefits means lower future payments than those currently scheduled. However, the alternative of doing nothing now could also mean lower future benefits. The potential strain on overall budgetary resources—resources for all other government activities—when the baby boomers start to reach age 65 eight years from now, and Medicare expenditures begin their rapid ascent, may cause lawmakers to curb Medicare spending. Taxes and premiums for Medicare are already lower than the pro-

1. Chapter 4 of CBO's recent publication *Budget Options* (March 2003) discusses in more detail approaches to slow the growth of both Social Security and Medicare.

gram's expenditures (for HI and SMI combined). That gap—now about $89 billion—is projected to grow to $191 billion by 2013.

Looking more broadly, spending for Medicare, Medicaid, and Social Security—the three federal entitlement programs most directly affected by the looming population trends—now absorbs 8 percent of GDP. If CBO's projections hold, that figure will rise to 14 percent of GDP by 2030. Beyond that year, spending pressures will intensify, with longevity continuing to increase and health costs continuing to grow. Simply weathering the demographic surge of the baby-boom generation will not be enough to restore the federal government's fiscal posture to its recent norms. By 2075, CBO projects, the cost of the three programs could climb to 21 percent of GDP, the largest portion of which would be attributable to Medicare. To accommodate the increase in spending, either taxes would need to be raised dramatically, spending on other federal programs would have to be curtailed severely, or federal borrowing would soar.

Economic growth is the principal engine to ensure that future retirement needs can be met. However, there is no free lunch. Effective measures will not necessarily be popular measures, and the longer they are deferred, the harder they will be to enact, as those affected grow as a share of the population.

The CHAIRMAN. All that you laid before us, and as the facts come in, it is clear to any of us that the sooner we make these adjustments, the better off we are going to be, and the recipient of the service provided by these programs is probably going to be better off, also. But projected outward, you use those figures. I used similar figures in opening comments this morning. That is unsustainable.

Congress will not put itself through those two alternatives of choice that you talk about, either forcing the consuming public to make considerably larger or different choice, private sacrifice or choice, and we are not going to, at least under the current Congress, and past records would also demonstrate that, make those kinds of choices to offset discretionary spending.

You project on page six of your testimony that Medicare by 2075 will consume the staggering 9.2 percent of GDP. If a high-end universal drug benefit with a 10-year price tag of $800 billion to $1 trillion is to be enacted this year, what kind of an effect would that have on the projections you have quoted?

Dr. HOLTZ-EAKIN. Well, if you will forgive me for doing the math in my head and not hold me to it precisely, $800 billion to $1 trillion over 8 years is less than percentage point of GDP at the outset; with compound growth over 65 years it could grow to be as much as another 2 percentage points of GDP. So we would be looking at an excess of 11 percent of GDP by 2075.

The CHAIRMAN. The one thing that is obvious to us when you project Medicare outward, and you made a reasonable extrapolation based on those figures, is that we have never been able to control those figures or costs to be accurate in our projections. You can do that in Social Security. The demographics are there. We understand where people are in their aging and all of that. But the one thing that we cannot incorporate into all of this is the dynamics of health care as clearly a dynamic economy today, and we never could and haven't, obviously, factored the change in care delivery and prescription drugs and we are now there trying to struggle with that.

So I have to assume that if you are talking 11 percent, you are probably off 20 percent. Is that reasonable? I am not an economist.

Dr. HOLTZ-EAKIN. It is perfectly reasonable to suspect that the variation is at least 20 percent. I gave you a variation—simply from moving one-half of a percentage point up—of 7 percentage points of GDP. It is enormous.

The CHAIRMAN. You state on page ten of your testimony that stimulating private health care plans to compete through premiums might reduce costs through greater efficiency and negotiated rates. First, I am correct to assume here that you are referring to a competitive model along the lines of the Federal Employees program?

Dr. HOLTZ-EAKIN. I think it is fair to say that I am simply talking about the large range of experience in economics, where having competitive pressures with a reward to efficiency on the supplier side and with a reward to matching purchased services to your preferences on the demand side will have a payoff for society as a whole. It is not intended to point to any particular competitive system that might be designed.

The CHAIRMAN. Second, could you elaborate a bit more on how such enhanced efficiencies might come about in such an environment where it applied to Medicare.

Dr. HOLTZ-EAKIN. I think in that regard, I would make two observations. The first is that with specific proposals for introducing competitive elements into Medicare, the ultimate impacts both in terms of quality of care, cost to the Federal Government, and cost to beneficiaries will depend importantly on the details and the degree to which incentives are embedded in the system. Without seeing those details, it would be premature for me to make any particular judgment.

The broader point that I would like to make is that Medicare resides within the private health care system. It is 17 percent of national health care spending, and the degree to which that larger private health care system is responsive to incentives will control the kind of cost growth that we see in this chart.

The CHAIRMAN. One of the factors of the consumption of GDP into these programs that is of concern, and my question is of that, total Federal taxes today absorb about 18 percent of GDP. By 2075, however, you say taxes as a share of GDP would be about an additional 7 percentage points higher if Medicare's projected higher cost were to be covered by taxes. What would be the effect on the economic growth if Federal taxes were to rise that much in that context?

Dr. HOLTZ-EAKIN. I think it is important to be careful about how those taxes would be raised. To the extent that those taxes were levied on saving, investment, risk taking—on capital accumulation, broadly speaking—economic growth would be impeded. Growth occurs through the accumulation of quality and quantity of skills, skilled labor, capital, and technologies. To the extent that those taxes were levied on the consumption that is at odds with savings and investment, then the impact would be minimized.

The CHAIRMAN. Let me turn to my colleague from Missouri, Senator Talent.

Senator TALENT. Thank you, Mr. Chairman. It is pretty clear from the information you have presented that the current situation, business as usual, if you will, is not likely to be politically or economically viable in the out years. Obviously, you are presenting the facts and then we have to decide what it is we want to do.

Clearly, if we could reduce the costs of traditional Medicare without impairing or even improving care, that would obviously help a lot. I am going to suggest something to you, but I want to just make a general comment first.

My concern is that as we approach this cliff, Congress is going to react the way it has reacted in the past when it wants Medicare savings. It is going to basically tighten the lid and reduce reimbursement rates and, in effect, pretend that we can get the savings we need and still get the services we want by just reducing the amount that we are paying for the services.

Then in order to justify that, what happens is the Congress—and let us face it, politicians are very good at this—scapegoats the providers. Well, the problem is all this waste, fraud, and abuse and people out there, and that is what we did with BBA 1997 basically, and it saved money, but it really hasn't worked.

Now, the other alternative is to take costs out of the system that aren't delivering anything in terms of care. I just talked about technology. Let me add one other one and then you can add your comments about it.

I think it is the case, Mr. Chairman, isn't it, that about 5 percent of the folks on Medicare are generating about 50 percent of the costs.

The CHAIRMAN. Something near that.

Senator TALENT. Now, that is a small enough group of people that it seems to me, at least on a pilot basis, we could try, particularly if we get the information systems up to where they need to be, identifying them when they come into the system and having some pretty good case managers work with their providers to try and reduce those costs in those cases and pull some of those costs out of the system.

I don't know, I probably should have asked this of Mr. Scully as well, but aren't there opportunities to pull costs out of this system in traditional Medicare so we can flat-line some of that growth a little bit, and isn't that a logical thing that we should begin trying to do?

Dr. HOLTZ-EAKIN. I can suggest a couple of things. The first is that one of the points that I tried to make in my written testimony was that to the extent that you can build incentives in for providers to actually reap some of the benefits of identifying those costs, the system itself will identify and take them out to the extent possible, and that is something that is desirable to get into a system.

The second is on the specific benefits of case management and disease management and identification of high-cost Medicare beneficiaries. The Congressional Budget Office has undertaken some preliminary investigation into these issues, which is far from complete, and it is really trying to take a hard look at data that track Medicare beneficiaries over a long period of time to try to identify the degree to which a small number are responsible not just for the costs in any single year but the costs over a long number of years, and the degree to which those costs can be traced to particular diagnoses and chronic conditions. Then the questions is. Can a system be designed that would, in fact, be useful for identifying, such beneficiaries controlling costs, and providing the quality of care that would be of interest to the Medicare program?

We would be happy to share that work, with you as it is completed and work with you in——

Senator TALENT. Perhaps in doing that work, you could look at the costs generated from those cases and make some assumptions. Let us suppose that we reduce those costs by 10 percent, by 15 or 20 percent. What does that do to the overall picture if we put this into place?

These are the kinds of things I am interested in doing, because personally, I think that there are ways—I talked about technology, we have talked about case management. If we could provide some liability relief to take some of the defensive medicine that is currently being practiced in both the public and the private sector, take that cost out of the system, I think there are billions of dollars being spent on things in health care that aren't related at all to

health care, and it is not waste, fraud, and abuse. It is things in the system that are causing providers to do this in order to relieve other stresses that are being put on them that doesn't have anything to do with care. We may be able to get our way largely out of this that way.

I would love to see—you can at least look at top lines and make some assumptions and provide some data, and if you do, I would love to see it.

Dr. HOLTZ-EAKIN. If I could make two comments about that, the first is, that as an economist, I am a great believer in the power of incentives, and the good news part of the comments you just made would be that perhaps incentives could help us to control this excess cost growth.

The bad news that I will put on your radar screen is that CBO's base-case projection assumes that costs grow faster than GDP by 1 percentage point. Historically, they have grown faster by 2.8 percentage points. There is an enormous gap between those two figures, which we have not built into these particular projections. So the degree to which incentives can rectify the entire problem remains to be seen.

Senator TALENT. Why is health care as a whole, the cost of health care in the private as well as the public sector, why is that growing—first of all, it is growing faster than costs in other areas, isn't it?

Dr. HOLTZ-EAKIN. Yes.

Senator TALENT. What, in your judgment, is that attributable to?

Dr. HOLTZ-EAKIN. Many people have looked at this, and I would say the broad consensus is that innovation and new technology are the key drivers of health care costs, followed by a range of other factors that you could rank in a variety of different orders—increased insurance, subsidies to that insurance, and a variety of other things, including aging of the population. But the technology component seems to be the common element that most investigators arrive at, and the degree to which we adopt the right technologies and spend our money as a nation wisely on those technologies is obviously crucial.

The second thing, as an economist, that I would warn you about is that cost is not the only way to measure those technologies. You would also want to assess the benefits in terms of their therapeutic value, and simply measuring cost doesn't tell you whether we are getting the right value for our dollar.

Senator TALENT. Yes, I understand that. You are saying what I think of as treatment or therapeutic technology, you know, the new form of oncology or whatever that costs a lot of dollars but is more effective in treating people, what you understand is that that is what is driving the cost in health care?

Dr. HOLTZ-EAKIN. New technologies.

Senator TALENT. But you see, there are new technologies being introduced all across the rest of the economy and they are not driving costs that much, and in some cases, they are reducing costs. I mean, the new technology is permitting people to be more productive. Is that phenomenon helping, or is it occurring in health care, and if not, why not?

Dr. HOLTZ-EAKIN. On a case-by-case basis, the CBO staff has looked, for example, has looked at some of the new prescription drugs and the degree to which they could substitute for older treatments and therapies and, as a result, perhaps result in cost savings. There is no clear conclusion on that particular front as yet. In some particular diagnoses, it appears that it is possible. In others, there doesn't appear to be any cost saving, but rather that drugs are an additional treatment that adds to total cost yet may yield greater patient satisfaction, and if so, then the lack of cost savings is worth it from an economic point of view. On balance, it is not obvious that these things break in the direction of saving costs in total.

Senator TALENT. Is it, and stop me, Mr. Chairman, if I have gone too far——

The CHAIRMAN. Complete your thought.

Senator TALENT. Is it inherent maybe in the nature of a system where payment is so predominately third-party pay? I mean, is that the problem in health care, that there is always somebody else who is paying for the health care and so you have, in effect, an unchained demand? Is that driving the costs?

Dr. HOLTZ-EAKIN. Senator, as an economist, I am sure it would be a dangerous thing for me to assign any single cause to the rising cost of health care, and I won't do it. But I will point out that one of the key incentives in any economic problem is to make sure that the individual making the decision has the proper financial inducement to weigh benefits and costs, and ignoring one side of that equation leads to bad decisions on the whole.

Senator TALENT. But, you see, I am not sure what we can do about that, because we can't have a system—I can't think of a system of reimbursement or payment that would be just and would produce health care for everybody that was not largely third-party pay. I mean, I think you could probably try and give people incentives to be more responsible for their primary care, the costs, the lower-level costs in health care. But once you get into acute care, we are going to have a system where you have either got an insurance company or the government or somebody doing third-party pay.

So really, on the highest level, it seems to me one of the things we have to do is try and figure out a way to reintroduce the right incentives, given that we have a third-party pay system. Is there any model out there that you know of that we can look at to try and accomplish that?

Dr. HOLTZ-EAKIN. I don't have a specific policy recommendation. It would be inappropriate for me to make one at this point——

Senator TALENT. Right.

Dr. HOLTZ-EAKIN [continuing]. But I would be happy to work with you if you had particular ideas that you wanted to try out. We could have a dialog and see which ones seem most promising.

Senator TALENT. OK. Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you for those questions. I think that when we get into that business of defensive medicine and all the other things that are driving health care costs external to health care itself—certainly, the tort reform we are attempting here and

that States are touching on a State-by-State basis is going to have some impact, also, on those overall costs.

We have been joined by our colleague, Senator Carper. We are pleased to have you with us. I would turn to you for any opening comment you would like to make. We just finished with Administrator Scully and we are now with our new Director of the Congressional Budget Office, Dr. Holtz-Eakin.

Senator CARPER. Good luck.

Dr. HOLTZ-EAKIN. Thank you, sir.

Senator CARPER. I just came here to wish you good luck. You take over with a budget deficit that is soaring past $300 billion and we are into a war that we have not paid for and are anticipating further tax cuts——

The CHAIRMAN. This has been a real upbeat place until you got here. [Laughter.]

Senator CARPER. You are a better man than I am to take this on at this time.

I apologize for arriving at this hour. It is my fourth hearing that I have been to and I have had some other things added to my morning, so I apologize for not being here earlier.

I am not going to give a statement but I would just ask, for you to take a minute and tell me one thing you would like for me to remember when I leave here either in response to questions or your statement.

Dr. HOLTZ-EAKIN. Asking an ex-professor to restrict himself to one thing is asking a lot. [Laughter.]

But one thing to remember is the current program is broken, and I can give you three things on top of that if you would like.

Senator CARPER. Give me three.

Dr. HOLTZ-EAKIN. The current system is broken. It will involve, as a result, trying to tradeoff either other smaller programs within the government budget or making the government budget larger and having a smaller private sector. The fourth thing I would point out is that Medicare is embedded within a larger private health care system. It is only 17 percent of our national health care spending. So to focus on Medicare alone is to run the risk of missing the larger picture.

Senator CARPER. Folks over at the Progressive Policy Institute, including a fellow named Jeff Lemieux, have given a fair amount of thought to these issues. I don't know if you have had any chance to spend time with him and to get the benefit of his thinking, but I have and I find it always refreshing and, frankly, valuable. He thinks outside the box and we need some of that as we approach the issue of Medicare in the 21st century and what to do with respect to the prescription drug program.

Mr. Chairman, I am sorry again to be late. I am glad that I got here before you finished and good luck. We look forward to working with you.

Dr. HOLTZ-EAKIN. Thank you.

The CHAIRMAN. Tom, I thank you for taking the time to drop by. We have all had busy schedules this morning and it is kind of you to come by and say hello to our new Director.

Let me ask a question on behalf of Senator Hatch, who had asked it of Mr. Scully and I think you were picking up on it prior

to his leaving. The question that was asked of Mr. Scully, again, he says, "Again, it is my understanding that the administration relied heavily on the demonstration projects involving PPOs." I am interested in your opinion on whether or not you can replicate these PPOs across the country if more than 90 percent of the people in the demonstrations are in counties where Medicare+Choice enrollment and payment rates are in excess of what fee-for-service will pay. Which details drive the cost of the PPO options? Are you prepared to respond to that?

Dr. HOLTZ-EAKIN. Well, I can't speak to how the administration prepared any estimates. I have not seen the details of any plans, so that would be premature. I can make some general observations that——

The CHAIRMAN. Please do.

Dr. HOLTZ-EAKIN [continuing]. Compared with Medicare fee-for-service, the wide range of private options available at the moment are in some cases cheaper and in some cases more expensive than Medicare. We heard several Senators remark that Medicare was the lowest payer in their area. Those are examples of situations in which the private options would be more expensive.

The second general comment I can make is that in any demonstration project that economists have tried to study—government training programs come to mind as an example—an important issue to be cognizant of is the degree to which the participants really pick the most opportune places and times to take advantage of such a demonstration project. To the extent that the PPOs we see in the demonstration are only located in those places where they are going to have their greatest advantage, they will not be representative of any nationwide PPO system that one might put in place. The same lesson has been learned in training programs, where those most likely to take advantage of training are those who can get the largest return from it, which skews the estimated returns to the training program.

The CHAIRMAN. Doctor, your table on page nine shows that if Congress were to try to address Medicare fiscal problems by either raising the eligibility age or by increasing beneficiary cost sharing, the resulting fiscal benefit would be remarkably small. Why is that the case?

Dr. HOLTZ-EAKIN. Well, in both cases, the options are actually relatively small. In the first case, moving the retirement age up by 2 years doesn't change the fundamental demographic shift of doubling the number of retirees per worker, and it also takes away the cheapest Medicare beneficiaries—the lowest 10 percent of the population—but not 10 percent of the cost.

In the second case moving the Supplemental Medical Insurance premiums up as much as is shown in that option really just changes the overall subsidy from 90 percent to about 80 percent, and as a whole doesn't change the basic financial structure very much.

The CHAIRMAN. You had given a scenario, and you spoke again to it with Senator Carper, of the long-term future of Medicare and the impact it has and choices, such as ultimately reducing benefit levels, raising taxes, reducing other spending or for increasing Federal borrowing—and all of these by very significant amounts.

I am confident we are going to make some changes, but I am not confident we are going to make them in such a significant way—I mean, I think we cannot say that that is our trajectory.

So as an economist, looking at this from an economic growth perspective, which of these four directions would have the least amount of harm on the country from a long-term economic growth perspective?

Dr. HOLTZ-EAKIN. I would characterize the problem slightly differently. The Congress will, in its deliberations this year and in the future, pick a structure not just for Medicare but for Medicare, Social Security, and Medicaid—the entitlement programs, all of which have this same basic characteristic growth path—and for the budget as a whole, which will or will not encourage consumption at the expense of saving, or will allow the country to accumulate greater resources in capital, labor, and technology. That is the fundamental tradeoff that these choices will influence. To the extent that the overall structure of the government budget is one that provides consumption in the present at the expense of saving for the future, other things being equal, we will see lower growth, and the question for the Congress will be, is that worth it in terms of providing those necessary benefits in the government budget that we want today and giving up some smaller amount of growth in the future.

The CHAIRMAN. I could see lurking in the back of your mind the Japanese model.

Dr. HOLTZ-EAKIN. I won't speak to that. I don't know what the Japanese model is——

The CHAIRMAN. No, I mean the current Japanese economy——

Dr. HOLTZ-EAKIN. I do not want the current Japanese economy, sir.

The CHAIRMAN. Thank you, because it is, in essence, that burdened economy, if you will, that is so consumptive of its productivity that it can't begin to produce again, it seems, and it is sitting out there for the last 10 years with almost no growth, or very little growth.

Dr. HOLTZ-EAKIN. I will spare you a long dissertation on my views on the Japanese economy. No one here deserves that this morning. One chart is probably enough.

I will say that you have hit the nail on the head when you point to productivity. Maintaining a rapid rate of productivity growth is the key to long-run living standards in the United States, and that is another way to pose the basic problem: to ensure that we grow large enough as an economy requires rapid productivity growth, and that larger economy will provide the resources for all such programs, public and private.

The CHAIRMAN. That really is the key. I am through with my questioning. Is there any further?

Doctor, thank you very much for taking time to be with us this morning. This is an area that I am quite confident you are going to be spending a lot of time on in the future, as are we, as we should, to create these new models that are so critical to the population of our country and in the overall economics of our country, the dynamics that we have talked about here just in the last few minutes. So we will stay connected, as I know you will, and I thank you very much for being here this morning.

The committee will stand adjourned.
[Whereupon, at 12:19 p.m., the committee was adjourned.]

APPENDIX

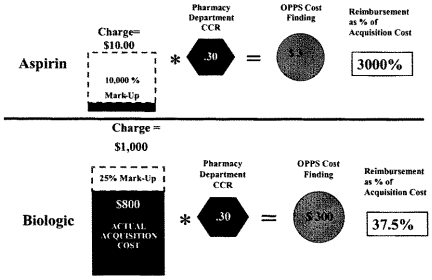
Medicare OPPS Threatens Patient Access to Critical Biological Therapies
March 20, 2003

Issue:

Effective January 1, 2003, the Centers for Medicare and Medicaid Services (CMS) cut reimbursement rates for many drugs and biologicals so dramatically that hospitals may no longer continue to provide them. These dramatic reductions are caused primarily by a fundamentally flawed methodology CMS is using to calculate rates in the hospital outpatient department prospective payment system (OPPS). The methodology is causing hospitals to be substantially under-reimbursed for the costs of many high-tech therapies, particularly biologicals and orphan drugs used to treat patients with rare disorders. In many instances, payment rates are less than hospital costs for acquiring – let alone administering – the therapy. Cuts this severe will force hospitals to make tough choices about whether to continue to provide these therapies or to divert treatment to physicians' offices, where reimbursement is more adequate. In either case, patient care will suffer.

To make matters worse, CMS introduced two new policies in its final OPPS payment rule that will deny Medicare beneficiaries access to important therapies in the future. These policies were implemented without any notice or opportunity to meaningfully comment, clearly violating the Administrative Procedure Act (APA).

Overhead Allocations and the CMS Methodology



Congressional action is imperative to ensure that patients continue to have access to these critical and lifesaving drug and biological in hospital outpatient departments – both those that exist today as well as those on the horizon that provide new hope for the future.

Major Concerns:

CMS' methodology creates a bias against higher cost therapies—potentially denying patients access to important medicines. CMS bases payments to hospitals under the OPPS on hospital charges, reduced to "cost" under a complicated methodology. Charges for each hospital outpatient department are reduced using that department's "cost to charge ratio." The average cost to charge ratio nationwide for pharmacy services is .3, meaning that on average, a hospital's charges for a drug or biological must equal 350% of its costs to even cover acquisition costs (see figure above). Any product with below average markup over the hospital's costs will be subject to reimbursement below those costs. Because of the way that hospitals typically structure their charge masters, this methodology creates a substantial bias against higher cost technologies.

CMS has labeled this phenomenon "charge compression." Although CMS is investigating the issue, Medicare beneficiaries should not be denied access to potentially lifesaving therapies in the meantime.

CMS' payment rates threaten access for patients with rare disorders. Many of the substantially under-reimbursed therapies in the OPPS are designated as "orphan drugs," used to treat patients with rare disorders. CMS had the authority to exclude from the OPPS all drugs designated as orphans by the Food and Drug Administration (FDA). Instead, CMS decided to exclude only those that have neither an approved use for other than an orphan condition nor an off-label use for conditions other than the orphan condition. Only four therapies obtained this exemption, leaving dozens of other products for patients with orphan conditions inadequately reimbursed, including 10 biologicals that actually meet the agency's stringent criteria.

CMS has overstepped its authority in ways that further harm patient access and threaten future innovation. This year, CMS applied a completely new "functionally equivalent" standard to eliminate transitional "pass-through payments" for a new drug in its final rule for OPPS. This standard is contrary to statute and was imposed without any notice and opportunity to comment, in clear violation of the Administrative Procedures Act (APA). Most important, this standard discourages innovation—the foundation of the biotechnology industry. It creates a strong disincentive for companies developing important improvements to existing therapy or new technologies that could be seen as "functionally equivalent" to another product. Often these advancements increase compliance and allow patients to tolerate the most effective treatment available. The transitional pass-through system is a means of ensuring adequate reimbursement for new products. By side-stepping this system, CMS has created significant doubt about the availability of pass-through payments in the future, making it more difficult for companies to invest in new technologies.

Second, the agency stated suddenly that it would no longer consider diagnostic or therapeutic radiopharmaceuticals to be "drugs" or "biologicals" for purposes of obtaining transitional pass-through payments, even though these products are approved as such by the FDA—once again overstepping its statutory authority. Congress clearly intended pass-through payments to be made for radiopharmaceuticals and even included them specifically in the pass-through provisions of the statute. Radiopharmaceuticals clearly are drugs and biologicals and CMS long-standing policy was to consider radiopharmaceuticals to be drugs. CMS should be required to

treat them as such for purposes of determining eligibility for pass-through status. Otherwise, patients could be denied access to these critical diagnostic and therapeutic therapies.

BIO's Position:

BIO urges Congress to act now to ensure that Medicare beneficiaries continue to have access to critical biological therapies in hospital outpatient departments. Accordingly, BIO urges Congress to enact the legislation necessary to accomplish the following goals:

- **Separate and adequate reimbursement for drugs and biologicals.** We fear that any CMS methodology that attempts to bundle drugs and biologicals will result in inadequate reimbursement for some products. Particularly for breakthrough products coming off the pass-through system, separate reimbursement must be maintained at levels adequate to cover hospital acquisition and pharmacy service costs.
- **Orphan drugs with small patient populations should be excluded from the OPPS and paid separately.** We support the position of the National Organization for Rare Disorders. For those products with larger patient populations, claims for their rare disease uses also should be excluded from the OPPS.
- **New products should be reimbursed upon FDA approval.** Currently Medicare's coding and reimbursement practices create delays in reimbursement for new products. These delays must be mitigated to ensure patients have access to medicines as soon as the FDA approves them.
- **CMS must be prevented from overstepping its statutory authority, as it has with radiopharmaceuticals and the "functional equivalence" standard.**
    - Determining which products are drugs, biologicals, orphan drugs, or medical devices should be based on the decisions of the FDA under the relevant statutes and regulations.
    - CMS should be prohibited from applying the "functionally equivalent" standard or any similar standard to set payment rates for drugs and biologicals.
- **Medicare reimbursement policy should preserve patient access to care in all sites of service.** BIO is concerned that problems in the OPPS will threaten patient access to some therapies in the outpatient hospital setting. We believe that physicians and patients—and not CMS payment quirks—should determine where medical services should be performed based on what is most medically appropriate. Any legislation changing Medicare reimbursements should have the preservation of patient access to care as its primary goal.

Contact:

The Biotechnology Industry Organization (BIO) represents more than 1,100 biotechnology companies, academic institutions, state biotechnology centers and related organizations in all 50 U.S. states. BIO members are involved in the research and development of health care, agricultural, industrial and environmental biotechnology products.

For other information and any questions, contact Sharon Cohen at 202-962-9200.

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