

**DHHS FY2003 BUDGET PRIORITIES
AND MEDICARE REFORM**

Testimony

Presented To

**THE COMMITTEE ON THE BUDGET
UNITED STATES HOUSE OF
REPRESENTATIVES**

By

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On

February 28, 2002

Mr. Chairman and members of the Budget Committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am the John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I am also Co-chair of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. I have previously served as the Administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) and also chaired the Medicare Payment Advisory Commission. My testimony today reflects my views as an economist and a health policy analyst as well as my experience directing HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or the Presidential Task Force.

My testimony today discusses the Administration's programs for Medicare and prescription drug coverage, the need for Medicare reform and the extent to which these needed reforms are being addressed.

The Administration's Medicare Proposals

The Administration has proposed to modernize and reform Medicare with a program that will include \$190 billion in net additional spending. Although the details are not included in the budget, the framework was outlined last year. The reformed Medicare program would include an improved traditional fee-for-service plan and improved health insurance options, so that ultimately, Medicare would look more like Federal Employees Health Benefits Program (FEHBP). Some of the important principles underlying the

reform include giving all seniors the option of a subsidized prescription drug benefit, providing better coverage for preventive care, allowing seniors to keep traditional Medicare, providing better options to traditional Medicare, strengthening the program's financial security and streamlining Medicare's regulations and administrative procedures.

Because reforming Medicare is likely to take some time to implement, and perhaps also to pass, the Administration is proposing some short-term changes that could be implemented quickly. The President has previously announced an initiative to create a Medicare-endorsed Drug Card. This could not only provide short-term relief, helping seniors get lower drug prices, but might also provide useful experience to Medicare in terms of administering a prescription drug program. The White House has indicated that a revised drug card proposal, with a public comment period, will be released shortly. The Administration has also developed a model Pharmacy Plus drug waiver that states can use to provide drug-only coverage to low-income seniors through Medicaid.

In place of the Immediate Helping Hand Program that was announced last year, the President has proposed a Medicare low income drug assistance program where states could implement a comprehensive drug program for seniors with incomes up to 150 percent of the poverty line without waiting for a full Medicare prescription drug program to be fully phased in. States already have the option under Medicaid to cover seniors up to the poverty line. This new program would provide a 90 percent match to the states for seniors between 100 percent and 150 percent of the poverty line.

The Administration has also provided incentives for new options to be included among Medicare's private plans, and has proposed to strengthen the existing Medicare+Choice program by correcting for previous underpayments. It has also proposed that two additional Medigap plans be offered in addition to existing ten currently available.

The Need to Reform Medicare

Although Medicare has resolved the primary problem it was created to address, ensuring that seniors had access to high quality, affordable medical care, there are a variety of problems with Medicare as it is currently constructed. The Administration has correctly assessed the most important of these flaws: inadequate benefits, financial solvency, excessive administrative complexity and an inflexible Medicare bureaucracy.

A part of the motivation for Medicare reform has clearly been financial. Concern about the solvency of the Part A Trust Fund helped drive the passage of the Balanced Budget Act in 1997. Part A, which funds the costs of inpatient hospital care, Medicare's coverage of skilled nursing homes and the first 100 days of home care, is primarily funded by payroll taxes. The changing demographics, associated with the retirement of 78 million baby-boomers between the years 2010 and 2030 and their longevity, means that just as the ranks of beneficiaries begins to surge, the ratio of workers to beneficiaries will begin to decline. The strong economy of the last decade and the slow growth in Medicare expenditures for FY 1998-2000 has provided more years of solvency than was

initially projected following passage of the BBA but even so, Part A is expected to face cash flow deficits as soon as 2016.

As important as issues of Part A solvency are, however, the primary focus on Part A as a reflection of Medicare's fiscal health has been unhelpful and misleading. Part B of Medicare, which is financed 75 percent by general revenue and 25 percent by premiums paid by seniors, is a large and growing part of Medicare. Part B currently represents about 40 percent of total Medicare expenditures and is growing substantially faster than both Part A and than the economy as a whole. This means that pressure on general revenue from Part B growth will continue in the future even though it will be less observable than Part A pressure. It also means that not controlling Part B expenditures will mean fewer dollars available to support other government programs.

However, as the Committee understands, the reasons to reform Medicare are more than financial. Traditional Medicare is modeled after the Blue Cross/Blue Shield plans of the 1960's. Since then, there have been major changes in the way health care is organized and financed, the benefits that are typically covered, the ways in which new technology coverage decisions are made as well as other changes that need to be incorporated into Medicare if Medicare is to continue providing health care comparable to the care received by the rest of the American public.

Much attention has been given to the outdated nature of the benefit package. Unlike almost any other health plan that would be purchased today, Medicare effectively

provides no outpatient prescription drug coverage and no protection against very large medical bills. Because of the limited nature of the benefit package, most seniors have supplemented traditional Medicare although some have opted-out of traditional Medicare by choosing a Medicare+Choice plan.

The use of Medicare combined with supplemental insurance has had important consequences for both seniors and for the Medicare program. For many seniors, it has meant substantial additional costs, with some plans exceeding \$3,000 in annual premiums. The supplemental plans also mean additional costs for Medicare. By filling in the cost-sharing requirements, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in greater use of Medicare-covered services and thus increased Medicare costs.

There are also serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health-status among seniors. Seniors and others pay into the program on the basis of income and wages and pay the same premium for Part B services. These large variations in spending mean there are substantial cross-subsidies from people living in low medical cost states and states with conservative practice styles compared to people living in higher medical cost states and states with aggressive practice styles. The Congress and the public is aware of these differences because of the differences in premiums paid to

Medicare+Choice plans but seems unaware that the differences in spending in traditional Medicare is now even greater than the variations in Medicare+Choice premiums.

Finally, the administrative complexities of Medicare, the difficulties that CMS and the contractors face administering Medicare and especially the frustrations that are being experienced by the providers providing care to seniors are issues that have been raised repeatedly during the past year. Although these are not new issues, the frustration being felt by providers has increased substantially. Physicians, in particular, have become increasingly vocal, as was evidenced in a number of hearings held last year. Among the many complaints that have been raised -- uncertainty about proper billing and coding, inadequate and incomplete information from contractors and discrepancies in treatment across contractors seem to be at the top of most lists.

In a report being released today that was requested by the Chairman, "Medicare Provider Communications Can Be Improved", the GAO verifies the validity of many of these complaints. Among their findings: information given to physicians by carriers is often difficult to use, out of date, inaccurate and incomplete. Medicare bulletins are poorly organized, contain dense legal language, are sometimes incomplete and are not always timely. Customer service representatives on toll-free provider assistance lines and websites didn't fare much better. Only 15 percent of the test call answers were complete and accurate, and only 20 percent of the carrier websites reviewed contained all the information required by CMS. CMS, in turn, was also criticized for having established too few standards for carriers and for providing little technical assistance to providers.

Assessing the Administration's Medicare Proposals

The Administration understands that Medicare needs to be reformed in many dimensions. Medicare's benefits are clearly outmoded, but Medicare problems are far greater than just the absence of prescription drugs and catastrophic coverage. Medicare needs to be modernized to accommodate the needs of the retiring baby-boomers and to be viable for the 21st Century.

The principles the President articulated last July and reaffirmed in the budget lead to a long-term modernization of the Medicare program that would be modeled after FEHBP and the work of the Bipartisan Commission for the Long Term Reform of Medicare. The specifics of such a proposal have not yet been released. However, the budget does contain several provisions that could improve Medicare benefits immediately, such as the prescription drug card program and a new Medicare drug program for low-income seniors.

The budget as presented raises at least two questions. If there is a lack of agreement about other areas of reform, should a prescription drug program be added to traditional Medicare now, with other reforms to follow at some time in the future? If not, is there any place for a drug program for low-income individuals, particularly one that ultimately could be integrated with the Medicare prescription drug program when it is implemented?

Although I believe it is important to pass a reformed Medicare program soon and that a reformed Medicare package should include outpatient prescription drug coverage, I also believe that just adding this benefit to the Medicare program that now exists is not the place to start the reform process. The most obvious reason is that there are a series of problems that need to be addressed in order to modernize Medicare. To introduce a benefit addition that would substantially increase the spending of a program that is already financially fragile relative to its future needs without addressing these other issues of reform is a bad idea.

I personally support reform modeled after the FEHBP. I believe this type of structure would produce a more financially stable and viable program and would provide incentives for seniors to choose efficient health plans and/or provider and better incentives for health care providers to produce high quality, low-cost care. This type of program, particularly if provisions were made to protect the frailest and most vulnerable seniors, would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program for the plan that best suits their needs.

I recognize that the FEHBP is controversial with some in the Congress, especially because of some of the difficulties the Medicare+Choice program has been having. It is important to understand, however, that many of the problems of the Medicare+Choice program reflect the exceedingly low payments that have been going to the plans where most of the enrollees live which the Administration has proposed to address. Inadequate payments added to the problem of the differential spending on seniors between traditional

Medicare and the Choice plans in the same geographical area plus the excessive regulatory burdens imposed on the plans during the first years following BBA helped transform what had been a vibrant rapidly growing sector into a stagnant and troubled one.

A second reason not to add a drug benefit without further reforms to Medicare is the difficulty of correctly estimating the cost of any new, additional benefit. Our past history in this area is not encouraging. The cost of the ESRD (end-stage renal disease) program introduced in 1972 was underestimated by several fold. The estimated cost of the prescription drug component of the catastrophic bill passed in 1988 and repealed in 1989 increased by a factor of two and one-half between the time it was initially proposed and the time it was repealed. Many in Washington are now eagerly awaiting the next round of Congressional Budget Office forecasts for the prescription drug bills introduced in the last session of Congress.

In addition to cost and estimating concerns, important questions remain about how best to structure a pharmacy benefit. Most recent proposals have made use of pharmacy benefit managers or PBM's as a way of moderating spending without using explicit price controls. These strategies, when used by managed care, showed some promise for a few years although more recently they have seemed less effective. But most PBM's have relied heavily on discounted fees and formularies and only recently have begun using more innovative strategies to more effectively manage use and spending. If Medicare is to make use of PBM's, decisions will need to be made about whether and how much

financial risk PBM's can take, the financial incentives they can use, how formularies will be defined and how best to structure competition among the PBM's.

All of these issues taken together reinforce my belief that just adding a prescription drug program to traditional Medicare is not a good idea. A better strategy would be to agree on the design of a reformed Medicare program and begin to implement changes now. It is likely to take several years to build the infrastructure needed for a reformed Medicare program and to transition to a new program. Producing the regulations needed to implement the legislation needed for a new drug benefit is likely to take at least two years.

Because of the delay in implementing major new federal benefits, a reasonable interim step would be to put in a place a program providing prescription drug coverage to help those most in need. There are a variety of ways such a program could be designed. The current Administration budget proposes one way. Last year, the Administration had proposed the Immediate Helping Hand program, a grant program to states that allowed states to extend existing pharmaceutical assistance programs, expand Medicaid coverage or introduce a new program. Another strategy would be to provide coverage first to those populations who already get special treatment under Medicare, that is, the qualified Medicare beneficiary (QMB's) and the specified low-income beneficiaries (SLMB's)

Whether or not the benefits of providing an interim program of outpatient prescription drug coverage for selected needy populations is worth the costs, is a decision the

Congress will need to make. Congress might well decide it's not worth the political capital it would take and focus its efforts directly on broader Medicare reform, which should certainly include a prescription drug program.

Let me re-emphasize the importance of making decisions on broader Medicare reform sooner rather than later. Concerns will always be raised about instituting significant changes in a program involving seniors. Whatever changes are made to the Medicare program may need to be modified for at least some subsets of the existing senior population. Some groups of seniors may need to be excluded from any change.

As we contemplate a Medicare program for the 21st century, it is also important to understand that the people who will be reaching age 65 over the next decade as well as the baby-boomers have had very different experiences relative to today's seniors. Most of them have had health plans involving some form of managed care, many of them have had at least some experience choosing among health plans, most have had more education than their parents and many will have more income and assets. The biggest change involves the women who will be turning 65. Most of these women will have had substantial periods in the labor force, many will have had direct experience with employer-sponsored insurance and at least some will have their own pensions and income as they reach retirement age. This means we need to think about tomorrow's seniors as a different generation, with different experiences, with potentially different health problems and if we start soon, with different expectations.

Let me summarize my points as follows:

- The Administration proposes to spend \$190 bil. in FY 2003-2012 to modernize and reform Medicare

Specific provisions of long term Medicare reform have not yet been submitted; framework and principles are outlined in the budget

Funding includes support for a Medicare-endorsed Drug Card, a new Medicare low-income drug assistance program, incentives for new private plan options and strengthening Medicare+Choice

- Medicare needs to be reformed

Solvency and financial pressures will continue as important issues

The current benefit structure is inadequate and unfair; existing geographic cross subsidies are also unfair

Medicare's administrative structure is excessively complex and bureaucratic; information given to providers is often inaccurate, incomplete, untimely and difficult to use

- Adding a stand-alone drug benefit to traditional Medicare without further reform is risky

Imprudent to substantially increase the spending needs of a financially fragile program

Actual costs of a new benefit will be underestimated if history is any guide

Still a lot of dispute about design issues

- Interim program for those most in need seems a reasonable first step

Several designs are possible: increasing the Medicaid match for people just above poverty, limiting the program to special populations, e.g. QMB and SLMB

Interim program may not be worth the political capital it would require

- Starting soon to design and implement a reformed Medicare is a good idea

Building the infrastructure will take time

Future seniors need to know the design of the future Medicare program

Future seniors will be different from today's seniors in terms of work experiences, income and education