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COST AND PAYMENT PLANS OF MEDICARE PART D

HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY SUBCOMMITTEE

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

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THURSDAY, SEPTEMBER 22, 2005

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION AND INTERNATIONAL SECURITY,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:34 p.m., in room SD–342, Dirksen Senate Office Building, Hon. Tom Coburn, Chairman of the Subcommittee, presiding.

Present: Senators Coburn, Carper, Akaka, and Lautenberg.

OPENING STATEMENT OF SENATOR COBURN

Senator COBURN. The hearing will come to order. I want to thank everybody for being here, and especially thank our witnesses. The purpose of this hearing is not to beat anybody up, but to find out facts.

The stakes have changed. Katrina has opened the eyes to what the responsibilities are upon us. We have Rita as well. I would like to talk to the person who names these hurricanes, where they come up with some of these names.

What we really hope to accomplish from this is to hear what we think is going to happen and what the costs are associated with what has been passed. I have a personal bias as a practicing physician, thinking that the Medicare Part D program, although it has great benefits in it, my personal belief is that it fixed the wrong problem. It is not about whether or not seniors need drugs—they do—and whether or not they need help getting those drugs—they do. I believe that. I see it every day in my medical practice. So I have a bias on the program.

What I am going to do today is just give a short opening statement. Our Ranking Member is testifying before another committee. Senator Carper will be here soon. When he does come we will allow him the time to give an opening statement, and then we will proceed with the questioning. We hope to make this a very brisk and fast-paced exercise because of all of the other things that we have going on.

Let me just start by asking unanimous consent to put my full statement in the record, and without objection, that will be made.

[The prepared statement of Senator Coburn follows:]

PREPARED STATEMENT OF SENATOR COBURN

Today's hearing will examine the unfunded liabilities the Medicare Modernization Act imposes on future generations and whether the new legislation will actually meet the needs of seniors.

The Federal Government has more urgent demands to make on the American taxpayers than ever before. Our nation faces a constant threat of terrorism, made more ominous by nuclear proliferation in Iran, China, and North Korea. We know that these tyrannical governments could share their weapons with terrorists. Nothing about the so-called "security" at our borders and ports prevents the transport of these weapons into our backyards. The war on terror requires massive military, intelligence, and law enforcement resources.

We also face long-term, expensive and previously unforeseen financial obligations to rebuild Afghanistan and Iraq. There is no more important, appropriate or Constitutional use of taxpayer dollars than defending the nation from those who would destroy our cities and our citizens.

Now, we must also reconstruct a disaster zone in our own country that covers 90,000 square miles. Millions of families, homes and businesses were affected by Hurricane Katrina. Cities and towns 300 years in the making must be rebuilt out of the mud of the Mississippi delta. The Federal Government is on the hook for every penny of it.

Americans are generous and proud, and so they will rebuild the Gulf Coast, Americans are far-sighted and security-minded, and so they will rebuild our new allies in the Middle East. What is unique, however, about these large new obligations is that they are occurring in the context of massive and unrestrained Federal deficits—already almost $600 billion this year. Unlike their elected officials, Americans understand about priority-setting from balancing their own checkbooks. When unexpected financial obligations arise, priorities must be set. Sacrifices must be made.

Since 2001, non-defense discretionary spending has increased by 36 percent. Let me repeat that. Since 2001, when we were attacked by a vicious enemy and embarked on an expensive war on terror, we increased NON-defense discretionary spending by a record-setting 36 percent.

During those years, we were a nation at war. We were rebuilding lower Manhattan. Oil prices were on the rise. We were facing a recession and tentative economic recovery. Those were years where we should have seen belt-tightening for discretionary programs. It was during these same years that Congress passed the biggest expansion of a mandatory entitlement program in four decades.

Every senior wants and needs access to life-saving medications. But when I go home and participate in town hall meetings, I ask this question of the seniors in the audience: "How many of you would deny your grandchildren any health care when they grow old so that the government can buy you prescription drugs today?" Not a single hand goes up. Today's hearing will examine if this is indeed the tradeoff we're facing.

With the drug benefit rolling out in January, I'm concerned if we can afford it. The President has identified "long term unfunded promises of our entitlement programs" as our greatest fiscal challenge.

Entitlement spending *already* accounts for over 60 percent of the Federal budget. I understand that by 2040, the Medicare deficit alone, which is not the only entitlement program, will consume half of all Federal-income tax revenues, before paying for other entitlements such as Social Security and Medicaid. I hope that our witnesses will confirm today if it is true that the new drug benefit will add $8.7 trillion to the unfunded liability through 2078, bringing the total debt to $29.7 trillion.

Today, the Federal deficit is nearly $600 billion. Just this fiscal year, the unfunded liability of Medicare is $126 billion. that means that after revenues kick in $217 billion from payroll taxes, social security taxes for Medicare, and premiums, another $125 billion must be taken out of the general revenues to cover the shortfall. Each year, the amount required out of general revenues will increase.

When Congress passed MMA, over 76 percent of all seniors *ALREADY* had drug coverage. Some argued at the time against expanding the program to pay for even the wealthiest Americans. They suggested that a more affordable approach would be to means-test the program, providing drugs for the neediest seniors.

I'm concerned that Part D may have enacted a massive cost-shift from the private sector to the U.S. taxpayer. The consequence of MMA is to actually force Medigap carriers out of business. What's more, many private employers and unions are currently paying drug costs for their retirees. Come January, however, those private payers will simply drop coverage, or, if they retain coverage, they'll bill the Federal Government for a large share of the cost.

There are plenty of reasons to worry about the fiscal outlook for Part D. However, just as worrisome is the potential effect it could have on patients. One of the best predictors of positive patient outcomes is the presence of private insurance. The reason is that you generally get better results when you keep the government out of the exam room. I worry that we are placing too much responsibility for a patient's treatment, especially his or her medication management, in the hands of a giant Federal bureaucracy instead of the important partnership between a patient, his or her doctor and family caregivers.

I'm also worried that as demand increases under this universal benefit, a natural response to contain the inevitable sky-rocketing costs will be price-fixing. Price-fixing often leads to drug rationing in the form of restricted formularies and onerous authorization requirements imposed on patients and doctors.

As Part D grows the Federal share of the U.S. drug market, there will be less competition—the ONLY downward pressure on prices. U.S. drug prices were high already, because American taxpayers subsidize the price-fixing behavior of other nations' socialized medical systems. Once we ourselves fall into the price-fixing trap, I'm concerned that innovation will disappear. More disincentives for innovation in drugs could spell disaster for patients. As a physician, I worry all the time about drug resistance. What will we do when there is no new antibiotic around the corner—when pharmaceutical companies only develop new *lifelong* drugs—specifically because these products won't be caught up in the new bureaucracy?

Today is a fact-finding exercise. I hope to hear from the experts and get some of the latest numbers out in the open and on the record. As we evaluate this new program, its role in our economy, and prospects for the future, I am grateful for the time and expertise of our witnesses.

Senator COBURN. I also will put into the record the information from the Medicare Trust Fund, and I would note that this year the trust fund, all of Medicare's expenses versus all of Medicare's revenues, ran a $125.6 billion deficit. That is "B" with a billion.

I would also put into the record that during the calendar year of 2006, that same deficit will rise to $187 billion. Those are not my numbers. Those are the Medicare trustee numbers. Those are the numbers that come from the trustees who are looking at the program. HI, the hospital insurance program, is doing well, based on how it has been managed, fees and everything that it has collected based on the premium. What is not doing well are the other programs that require participation. So without objection, I would like to enter the Medicare trustees' projections into the record, as well as the projection combining those on a yearly basis, rather than a fiscal yearly basis into the record.[1]

With that, I will ask Senator Akaka if he would like to have an opening statement.

OPENING STATEMENT OF SENATOR AKAKA

Senator AKAKA. Mr. Chairman, thank you so much for holding this hearing. This is very important to our Nation and our people. I want to apologize. I just got a call. I have to go back to the floor on my amendment that is pending, and ask that my full statement be placed in the record.

Senator COBURN. Without objection, so ordered.

Senator AKAKA. Thank you.

[The prepared statement of Senator Akaka follows:]

PREPARED STATEMENT OF SENATOR AKAKA

Thank you Mr. Chairman. for many years, I supported efforts to establish a meaningful, comprehensive Medicare prescription drug benefit. However, I voted against the Medicare Prescription Drug, Improvement, and Modernization Act of

[1] The charts appear in the Appendix on pages 37 and 38.

2003 (MMA) for several reasons. I believed that the bill was extremely complicated. It contained lapses in coverage, and included burdensome means tests and a provision that will cost taxpayers huge sums of money that will largely go into the pockets of drug companies.

The negative impacts of this new law will be even more troublesome given the disturbing trend of decreasing benefits for retirees over the past few years. Many seniors are being forced to rely on Medicare, which is providing a less generous benefit than what seniors currently enjoy. If Medicare beneficiaries lose their employer-based coverage, they may have to pay more for a Medicare drug benefit that provides less comprehensive coverage. It is estimated that approximately 2.5 million people will lose their coverage and be forced to depend on a benefit that is not as good as their existing coverage. The intent of having a Medicare prescription drug benefit should be to expand and improve coverage for seniors, not merely shift the financial burden of existing coverage to the Federal Government.

The prescription drug benefit is complicated. In October, Medicare beneficiaries will find out which Medicare drug plans are available in their area, and face a confusing set of questions. Beneficiaries will have to decide whether to enroll in the Medicare drug benefit and, if so, which drug plan to select. Those with existing coverage must first determine how their current drug coverage will be affected and, if continued, whether their current coverage will be more or less comprehensive than the Medicare drug benefit. also, the implementation of this benefit will be difficult due to the complex design of the prescription drug benefit plans and low-income subsidies.

In particular, I am worried that seniors will not have access to the information they will need to make informed choices between private plans that would provide them with the best benefits. Further complication this arduous task is meeting the different needs and challenges of communities to make sure that no one will be unfairly denied access to assistance seniors are entitled to under the law. In crafting the law, I wanted seniors to have the option of participating in a Medicare administered drug plan rather than having to choose from private plans that will offer different benefits.

Furthermore, the new Medicare drug benefit plan includes a major gap in coverage for drug spending between $2,251 and $5,100 for some beneficiaries. This is often called Medicare's "doughnut hole." According to the Congressional Budget Office, more than on in every four of all Medicare beneficiaries are projected to have drug spending that falls in the range of the doughnut hole. I disagreed with the inclusion of the doughnut hole. No other insurance program that I know of operates like this program. Despite paying premiums, beneficiaries will not receive any help with their drug costs when they are in the doughnut hole.

I also found the assets test used to determine the low-income subsidies for the prescription drug benefit to be unrealistic. According to Families USA, the assets test will deny subsidies to 2.8 million low-income seniors with even a small amount of assets. Additional assistance should not be unfairly denied to deserving low-income seniors.

I also opposed the liegislation's imposition of a means test for Medicare Part B, which I did not believe was appropriate for an entitlement program. This will complicate the process for seniors and create administrative difficulties for the CMS.

It is hard to imagine that, as the Federal Government has assumed the cost of helping seniors obtain their prescription drugs, Medicare would be prevented from using the bulk purchasing power of the millions of its beneficiaries to lower drug costs for the program. This onerous prohibition was also included in the MMA.

In addition to ensuring adequate and affordable prescription drugs for the nation's senior citizens, we need to bring about massive reform of drug patent laws so that generic drugs can be made available more quickly in an attempt to slow the massive increases in drug costs. Too often drug companies are allowed to artificially extend the length of their patent protections on their products through the creative exploitation of loopholes in prescription drug patent laws. We must act to slow the increasing costs of prescription drugs.

Before I conclude, I want to take a moment to recognize the work of all the individuals in Hawaii who help Medicare beneficiaries understand their options. I also wish to recognize Mary Rydell, the CMS Pacific Area Representative, Christine Messner, the Social Security Administration Pacific Area Public Affairs Area, and Pamela Cunningham from the Hawaii Department of Health's Sage Plus program, for their outstanding efforts in promoting the understanding of Medicare Part D. I greatly appreciate the efforts of Barbara Kim Stanton and the AARP who help increase the awareness of the choices that beneficiaries will soon have to make. I was delighted to take part in several events during the August recess with these dedicated individuals.

Mr. Chairman, I remain committed to improving and simplifying the Medicare prescription drug benefit so that all seniors are able to obtain all of the medications that they need. Our seniors deserve no less. I look forward to working with my colleagues to correct the mistakes of the MMA and fulfill the promise to seniors that the Federal Government will help beneficiaries get the drugs they need.

Thank you, Mr. Chairman.

Senator COBURN. Senator Lautenberg.

OPENING STATEMENT BY SENATOR LAUTENBERG

Senator LAUTENBERG. I hate to rain on the parade, Mr. Chairman, but I will take an opportunity to make a fairly short statement.

The one thing that I learned when working with you, with your background as a physician, that there are different perspectives on ways to solve problems that we can agree upon are necessary for resolution, but the question is how much of our national resource do we devote to health care?

When you look at the results of the work done in our society on the medical research side, it is pretty astounding, thank goodness. And I confess to being not addicted, a user of some things that I get regularly, and it helps so many ways. When I look at the fact that my father died when he was 43-years-old, and my father was a health faddist, and I look at the luck I have had in life and see that I am fairly fit for my age, and those in the room probably know I am more than 50, but the fact of the matter is it is helped by a cholesterol-lowering drug, and something to keep tennis from getting too much of an elbow, etc. So I have great sympathy for the people who use these things. I believe that the beneficiary of appropriate means share the cost.

So when we look at things, I think this is a timely hearing, and I respect so much your experience, but also your focus on how we reduce the cost of things. I know you are not picking on health care, that we talk about lots of things, and I share some of the anxiousness to get those costs reduced. But we found out last week, Mr. Chairman, that health care costs increased almost 10 percent last year.

Now, one of the principle reasons for the skyrocketing health costs is the price of prescription drugs. You know this better than the people on Medicare, because Medicare does not currently cover prescription drugs. I have long supported the creation of a prescription drug benefit in Medicare, but I voted against the new Medicare drug bill 2 years ago because it is a totally, inadequately complicated plan that will leave many Medicare recipients with more confusion than coverage. In fact, the bill contains an unbelievable provision that actually forbids Medicare from using its buying power—this astounds me, Mr. Chairman—to bargain for the best possible price on prescription drugs. We see what happens with VA. VA has every right and every responsibility to negotiate for drug prices, and they get significant reductions.

So we hear a lot about the free market, and I know something about that. I was in the business world for many years. But I can tell you this, in the free market, businesses always negotiate for the best possible price on everything they buy. That is far from the only problem with the current law.

The new Medicare law simply does not provide adequate coverage for seniors whose lives are totally dependent on these drugs. We have all heard about the donut hole in the law. It means that after seniors receive a particular amount of drug coverage, they will then be cut off for a significant period of time, yet they still have to pay the premiums, and it is something around in the, I think, 3,000 plus area that they have to be responsible for. So they will pay the monthly premiums to insurance companies that are not going to cover their prescriptions.

To make matters worse, when we were considering this bill, the Administration misled Congress about its cost. I am not saying it was intentional, but that was the ultimate outcome. Tom Scully, who is head of the Center for Medicaid and Medicare Services—he was the head at the time—threatened to fire the chief Medicare actuary if he revealed the true cost of this bill to Congress. I asked GAO to investigate the legality of Mr. Scully's action, and GAO found out that Mr. Scully was so far out of line that he should repay part of his salary to the government. That was more than a year ago. We are still waiting for him to pay back the taxpayers.

Then there was more. We found out that there were some fake news stories about the new Medicare law, were distributing them to TV stations. One of our witnesses, identified by the fact that she is the only one at the table, was featured, as the reporter, Karen Ryan, who extolled the virtues of the Medicare law, did not talk about the donut hole or other problems. I asked GAO to evaluate HHS's activities. The GAO found that these fake news stories were illegal propaganda.

Mr. Chairman, to sum it up, this new Medicare drug law has been plagued by lack of candor. The focus of our hearing today is on the failure to be honest about this bill's costs, but we are also seeing a lack of truthfulness to seniors about the problems like this donut hole, and we have seen the lack of accuracy for the American people, when the Administration concealed its role in the fake news stories. I did not think it was proper. It was decided and we are on our way.

But I hope our hearing today is going to help us thrash out the truth about the upcoming Medicare drug benefit, and I thank you, Mr. Chairman, for doing it.

Senator COBURN. Thank you, Senator Lautenberg. One of the things that I hope we will get into, if the witnesses would just consider this, your testimonies are going to be included in the record. We would like for you to limit your opening remarks, so we can ask questions. But one of the things I do not think the American people understand about the price of drugs in the United States, is that there are single purchasers in lots of other places in the world. So consequently, Americans pay two to three times the price at retail for the identical drugs that they could buy in countries where there are price controls.

What that has essentially done is forced the cost for research for all the wonderful new drugs we have—I mean just to share with you, there is going to be a study that is going to be a breakthrough, going to be announced in the next 6 months, on a treatment to stop Alzheimer's in its tracks. I mean it is great stuff. The enzyme that

causes that disease has now been identified. It is the secretase enzyme. It is going to stop it.

Now, the cost of that drug is going to be enormous. Why? One, there is margin, but because when they go to sell it, they are going to have to negotiate a low price everywhere else, but we are going to pay a high price.

How does that work out? With Medicare Part D—and we have seen good competitive bids come in—which is lower than what they thought, but the total cost for drugs in the country is not going to go down. The total cost for the drugs in the country is going to stay the same or go up, because we are going to continue with the same cost shifting that Medicare has induced in every other aspect of health care. If you look at any drugs out there—and I see them every day as I practice medicine on the weekends and on Monday mornings from 6 to 9 o'clock. What we see is price increases of 6, 8, 9, 10 percent this year. What we see is 30 percent price increases over the last 3 to 4 years when we have had total inflation of less than 10 percent.

Those price increases are coming because we are paying for the research. We are also paying to subsidize everybody else's drugs in the world. At the same time we are not protecting the intellectual property of the pharmaceutical industry. China copies it. We have not done a good job of enforcing that in trade.

So there are a lot of reasons why our drugs cost so much in this country, but it is important for us to understand how we got where we are. That is why we want to know what is happening now.

With that, I will turn to our first witness. Leslie Norwalk is the Deputy Administrator for the Centers for Medicare and Medicaid Services. She directs the task of—and she has had a tough job, I want to tell you, and by the way, done a great job, because I know lots of congressional offices and Senate offices have worked with you. Even though I do not agree with it, I am out there helping seniors try to figure it out.

Ms. NORWALK. Thank you.

Senator COBURN. Hundreds of changes that were made in the Medicare Modernization Act, as well as the Part D program and enrolling.

We welcome you. Thank you for your hard work. Thank you for the service to our country and the service to seniors.

TESTIMONY OF LESLIE NORWALK,[1] DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. NORWALK. Thank you, Mr. Chairman, Senator Lautenberg Thank you for having me here today to discuss the cost of the Part D benefit. I think this coverage is critically important as we go forward for reasons that you both mentioned. Medicare beneficiaries today, and certainly those of tomorrow, desperately need drug coverage in order to reduce their costs for health care.

I would like to start today with a little bit of background about how this came to pass, and one of the many reasons why it is that the Medicare drug benefit is so necessary. When Medicare was created in 1965 the cost of health care was mainly in physician office

[1] The prepared statement of Ms. Norwalk appears in the Appendix on page 42.

visits and hospital visits, and prescription drugs did not play a critical role in the treatment of individuals. I suspect at the time there might have even been house visits by doctors. Certainly things have changed a great deal in 40 years. Part of that great deal is, in fact, Mr. Chairman, all the new drugs that are coming down the pike to do things like help cure Alzheimer's. And yet, if you do not have access to those drugs, they cannot help you. It is quite true that many of them can be very expensive.

One of the things is that we spend a lot of money on heart disease. Just for example, in this country, we spend a lot of money on angioplasty and bypass surgery. These are two things that Medicare currently covers, and yet today, the Medicare program does not cover basically beta blockers and statins which cost around $1,000 or less a year. And it does not really make sense in this day and age for a government program as a public policy to not do things like preventative care and to not have prevention as a focus. I am sure as a physician it is going to be one of the key things you do with every patient.

So from a government perspective, we need to be out there talking about prevention. One of the things that the Medicare Modernization Act in fact did was allow a "Welcome to Medicare" physical for those who enter the Medicare program, in those first 6 months, so that we can stop the need for angioplasties and bypass surgeries, and give them the prescriptions that they need and a way to afford them so that they do not incur the costs on the Part A and Part B side of Medicare.

Of course, when you do that scoring, any savings that would have accrued to the hospital side or the physician side is not counted in that score, just to make that point.

Senator COBURN. I run into that problem all the time up here. [Laughter.]

Ms. NORWALK. One of the things I would like to do is talk about the five basic principles of the Medicare Modernization Act surrounding the drug benefit, just as a context setting exercise.

The first is that it is available to all beneficiaries, whether they are 65 and over, whether they are disabled, whether they are in Medicare fee-for-service or in a coordinated care plan, something known as Medicare Advantage. It does not matter if they have a preexisting condition, or if they get their drugs by mail or retail. All individuals in the Medicare program are eligible for this coverage.

While that is terrific, there are lots of beneficiaries that need additional help. As Senator Lautenberg pointed out, there are often either gaps in coverage or premium payments, and many beneficiaries cannot afford those. Consequently, the program is set up to provide additional help, not just for those who are dual eligible, but also for individuals who are not in the Medicaid program, yet still have incomes limited enough that they need additional help. We have been working very diligently to find those individuals to get them enrolled so that they do not have the burden that some other beneficiaries may have in terms of just paying the basic premium, for example.

The third important tenet is keeping retiree health plans. About 11 to 12 million individuals in the Medicare program today are for-

tunate enough to receive their coverage through a retiree health care plan. Each plan is different depending on the employer and the union, certainly, that would offer it. But every beneficiary I have ever met who has this coverage is very interested in retaining that coverage, and over time they had been concerned about losing it. The reason that concern exists is because in 1988, merely 17 years ago, 66 percent of all large employers had retiree health plans. That number today is 33 percent, cut in half. For those who are newly hired, only 10 percent and fewer have access to retiree health plans.

Fourth is catastrophic coverage. No matter what your income, if you are going to have a blockbuster drug—say you have cancer or leukemia and you need Gleevec, and it is $40,000 a year, except for maybe Warren Buffett, that is something that really gives you pause. How can I keep myself alive and spend $40,000 a year? So no matter what your income, the catastrophic coverage piece is a very important part of the program.

And finally, it is voluntary. Many beneficiaries do not like change. They may not be interested in this benefit for whatever reason, and may take a year or two to feel, "Yes, maybe I do need this coverage after all." They can choose, and if they like it, fantastic, and if they do not like it, that is their option.

I am going to have to sum up quickly, but I wanted to talk briefly just about the five different categories of individuals if I may, and how it is that we look at the program going forward. I think it helps us categorize costs as well when we get to those questions.

The first of the five are those that are dual-eligible. There are about 6.2 million beneficiaries that are dually eligible. They will all automatically be enrolled in the Medicare prescription drug program between now and January 1, so that each and every one of them will have coverage, regardless of where they live, including in a hurricane impacted area, so that they can have access to drugs anywhere.

In the second group are those in the Medicare Advantage program, that more comprehensive program outside of fee-for-service. There will be, we expect, about 6 million beneficiaries enrolled in that program. They too will be automatically enrolled in the same Medicare Advantage plan that they are in now, except that plan will have drug coverage. They can opt out later if they choose to.

The third group are those employers that I mentioned before, those in retiree health plans. We expect about 10 million of them will still be in these plans beginning next year. Rather than being in the Medicare drug benefit, these 10 million will be in a plan that would be considered creditable coverage and that their plan is worth as much as the Medicare benefit. Those 10 million, each of them as individuals, the subsidy would go to their retiree health plan for a portion of their drug costs.

The fourth group are those people that are eligible for extra help, and yet are not in the Medicaid program. There are about 8.4 million of them we think, and we are searching long and hard to find as many of them as we can before November 15, so that when they sign up they will know that they will have that extra help.

Then finally, the fifth is the general Medicare population. There are about 12 million that I did not include in the first four buckets.

I personally believe strongly in the Medicare drug benefit. I am happy to address any of the concerns that Senator Lautenberg or you have raised about cost and coverage, and am certainly happy to talk about the positive things. I think there are many. I just thank you for inviting me and giving me this opportunity to explain the drug benefit.

Senator COBURN. Thank you very much, Ms. Norwalk. Let me clarify. You said it is voluntary, but if you are dully enrolled, it is not voluntary.

Ms. NORWALK. That is correct. You would automatically be enrolled, but there would be no cost to you from a premium perspective except you would pay copayments for drugs just like——

Senator COBURN. Except it is not voluntary.

Ms. NORWALK. I suspect if you did not want drug coverage, you could opt out, but there is no——

Senator COBURN. There is no mechanism for—I think that is just one of the important things, and if you are in a Medicare Advantage program now, it is not voluntary. You can later opt out, but you are going to get in it, you are going to be enrolled in it whether you want to be enrolled in it or not right now; is that correct?

Ms. NORWALK. You would be automatically rolled over, but you do have the option even before December 31, before the coverage starts, to not elect that prescription drug coverage.

Senator COBURN. There is a lot of debate among fellow Senators and throughout the country about what this thing really costs. If we are going to state here unequivocally, prevention is important, access to medicines is important. And I talked about this a lot because I have a lot of seniors today that may choose between eating and taking a pill. It is a real problem out there. Part of the problem is my profession because we prescribe the most expensive medicines that do 100 percent when we can prescribe one that costs 10 percent that does 95 percent, so part of it is on our part that this has happened. Part of that is demand pulled from the drug industry in creating that such as buying the lunches for everybody in an office every day, which we do not accept in our office, by the way.

But the CBO estimated last month that Part D will actually cost, over the next 10 years, $855 billion. What do you think about that?

Ms. NORWALK. I would first start out by saying projections are incredibly difficult, whether it is the Office of the Actuary or the Congressional Budget Office, and both would admit that estimating something even before it is begun has been incredibly hard.

Two of the key components of that estimate—if I just leave it to 2006, for the first year—two important components of that are something called the benchmark or what the average premium is of all the plans that have come in. Now, this average is not a weighted average, it is just every single plan that comes in is worth one. What is the average of that?

That average is important because the Medicare program subsidizes 74.5 percent of that average. The original estimates were overstated, and you can see that in the beneficiary premium numbers, that the initial estimate was $37 a month and now it is $32.20. What that means is actually a fairly significant change in what you will see between the mid-session review numbers that

the Office of the Actuary has out now and what will be in the President's budget next year. There has not been a re-estimate. But because of that change in per beneficiary subsidy, it is many billions of dollars cheaper than they originally estimated in 2003 because of competition, frankly, and the fact that the drug companies did a good job of negotiating with the insurance companies who are offering this benefit, and bringing in a lower price, not just the drug companies, but the pharmacies.

I do think that the cost will actually come down from the estimates that were in the mid-session review numbers, and I suspect that the Congressional Budget Office as well will take another look once they have the new numbers.

Senator COBURN. But according to your testimony, from $37 to $32, or $36.50 to $32, that is about one-ninth to one-eighth. So if you take this $855 billion and you take $110 billion off it, we are still at $745 billion, compared to $460 billion, which was the Administration's original estimate through OMB for the cost of this program over 10 years.

Ms. NORWALK. Let me say a couple of things. The first point is that the Office of the Actuary's initial estimate was $535 billion, just to be accurate, and it spanned the years of 2004 to 2013. If you think about how that—because it is a 10-year number, what happens 2 years later is that 2004 and 2005 drop off. Those are 2 years where we do not have a drug benefit at all. And instead you add on the back end two expensive years because we have more beneficiaries, and those beneficiaries for each year, basically when you add 2014 and 2015 to it, you are taking off 2 years at basically zero and adding 2 years which are basically——

Senator COBURN. That is a great explanation. Now give me your opinion. Is it going to cost more than the $530 billion in real dollars over the next 10 years that you all estimated?

Ms. NORWALK. Over the next—$535 billion between now and 2013, in my estimate, no. And the reason I would say no is because I am hopeful that we will have a very high number of participants. The Office of the Actuary estimated 39.4 million in this first year. I am hopeful that we do that well. I think Wall Street has been a little more skeptical, and has come in with estimates that are less than that. And if fewer people sign up, you have two things that—two different interactions that can occur first. Just the overall subsidy would decrease by the numbers that do not sign up for the benefit because it is voluntary. And the second part that happens really depends on those who do sign up, what is the mix; is there adverse selection, for example; and are only the sickest people signing up?

And figuring out that number for one year alone is difficult, but when you do it over year after year, and how that compounds is also difficult.

I think the other reason that these are complicated figures and difficult to discern, is that what happens this year? What is the experience that the drug plans have in offering the benefit in year one, and how does that impact on how they bid in year two?

Certainly when we have an average premium of $32, that means that a significant number of plans will offer at less than that. Almost every beneficiary in the country will have access to a plan

that will be less than $20 a month, and a significant number of them will have access to plans even less than $10 a month. So in that regard, well, if the lower premiums mean that more will sign up, there may not be adverse election.

Senator COBURN. So if there is not and everything goes the best it can go, everybody that is not on a Medicare drug plan is going to pay a significantly higher price for their drugs in the future; is that true?

Ms. NORWALK. Repeat the question, please?

Senator COBURN. If everything goes as best it can go to where you got the enrollments and there is not adverse election, everybody in this country who is not on Medicare D is going to pay a higher price for their drugs? Somebody is going to pick up this difference.

Ms. NORWALK. I actually think it depends on the type of drugs. Fifty-five percent of all the drugs consumed in the United States are generics. Generic drugs are cheaper in the United States than in nearly every other country in the world in spite of price fixing. Not true for brand name drugs, certainly, but as more drugs become available off patent in generic form, I do think those prices will come down. So I think it really depends on the drug mix that an individual is taking and whether or not a generic is available for that individual.

I think even that is a more complicated question than just if you are not in the Medicare program will you pay more. I think it depends on what disease you have and what drugs you need to take going forward.

Senator COBURN. What is going to happen, in your estimate—and this is a guess and nobody is going to hold you to it. What happens if the formulary is such that patients cannot really get what they need because a decision has been made to make the formulary—and by formulary I mean the choice of drugs that you can have—you cannot have the best or you cannot have the one you need, you can have second or third best? If we are getting close on numbers, what is going to happen in terms of—are you all going to change the formulary to stay within the numbers?

Ms. NORWALK. Well, one of the things that the Medicare Modernization Act requires is that we use U.S. pharmacopeia to put together a standard set of classes and classifications as a model. If the drug plans come in with drugs according to that model, then they can have an automatic pass, if you will, at the formulary.

Now, we have been reviewing—each and every formulary was reviewed by CMS and approved prior to being used. The second important piece in terms of how the formulary is done is that we have required six classes of drugs that all or substantially all of them must be covered in a formulary, including antidepressants, antipsychotics, anticonvulsives, anti-cancer drugs, immunosuppressants and HIV/AIDS drugs. So a significant number of drugs in fact must be covered by these plans, and that will, I think, limit the number of appeals that we have and any possible disruption we might have as individuals move from, say, Medicaid to Medicare, or frankly, other forms of insurance into the Medicare program. I know there has been great concern about that in particular.

Senator COBURN. You concern me a little bit, as a two-time cancer survivor, that oncologic drugs were not mentioned.

Ms. NORWALK. No. Anti-cancer drugs, yes, they are.

Senator COBURN. Thank you. I have one final question and I will go to you, Senator Lautenberg.

In your testimony you mentioned that 76 percent of the seniors prior to Medicare Part D had some drug coverage.

Ms. NORWALK. Correct.

Senator COBURN. I am not going to put you on record with this question, but I am going to put you on record with a second one. Senator Lautenberg alluded to the fact that lots of people are going to get this benefit that have tremendous means, and very few people are going to need the drugs that you described, thank goodness. Would you not agree that a significant means testing for Medicare Part D would be a way, in what we face today, to put this benefit to the people who really need it and to those that are secure enough and have the resources to pay for it themselves, like myself, that we would be better off as a Nation?

Ms. NORWALK. So you are suggesting that like we will be starting to do in Medicare Part B, that we should, as we call it, income relate the premium?

Senator COBURN. You have a very smooth means test. You can call it "income relate the premium," but what it is is the cost of Part B goes up if you have more assets and you earn more income. If that is good enough for getting into a doctor's office, why is it not good enough for buying your drugs?

Ms. NORWALK. I am glad you are not putting me on the record for this question.

Senator COBURN. I am not asking you to give an answer reflective of the Administration. I am just asking you to logically answer that question. Why would Senator Lautenberg and I both be eligible for this? Granted there is a slight means test in this—I do not mean to imply there is not—but why should the government pay 30 percent of my drugs?

Ms. NORWALK. I think part of the answer is, for whatever reason, if someone is—I am quite sure that you would be very good to take your beta blockers and statins and so on and so forth. I have no idea what the mentality is, why someone actually might not take them, whether it is income related or otherwise, but we certainly hope that whatever we do as a public policy, even if it were to cost more or less depending on your income, that we would at the end of the day encourage people to take the beta blockers and statins and avoid the angioplasty and bypass surgery, because even though it does not count, it is an important piece of the overall Medicare program on the A&B side.

Senator COBURN. More importantly, that we have government programs of prevention so that you do not end up with hypertension, hyperlipidemia and all the other diseases that preclude the need for beta blockers and ACE inhibitors and statins.

Senator Lautenberg, you have been very patient with me. Thank you so much. I would note that we have a vote that starts at 3:10. We will allow Senator Lautenberg to continue his questioning. Then if you have any additional statements on the basis of questions that have been asked of you, I will submit some in writing

for you to answer, and hopefully Senator Carper will be here at that time too.

Senator Lautenberg.

Senator LAUTENBERG. Interesting exchange, Senator Coburn. I do not know about Ms. Norwalk, but there were times when you left me sufficiently far behind in terms of the types of products that we are talking about. I just do what the doctor tells me. [Laughter.]

Ms. NORWALK. Wise counsel.

Senator COBURN. As long as you have a good doctor, that is great.

Senator LAUTENBERG. So far he is doing well. I hope he lives a long time. [Laughter.]

Senator COBURN. Senator Lautenberg, you do know the rule, is you always want to have a doctor far younger than you.

Senator LAUTENBERG. Well, as Strom Thurmond once said at his 90th birthday, talking about his health, he thanked everybody for being there, and he said, "I hope you'll all join me on my 100th birthday." And he said, "You'll be able to if you exercise and eat right." You will be here.

Enough of this good feeling. Let us get on to the business. You raised an interesting question about means testing, and unfortunately, I do not think we can accomplish a full review of that in this kind of forum, but that policy is kind of live and let live, and I think it has been said by other people. It would require a very thorough exam, and I would drag it into tax policy all together, because when I hear that we are going to have an $850 billion cost over a 10-year period, I think is what you said, and I look at how people like you and me got tax reductions, they are going to cost closer to a trillion over the 10-year period, so we have enough money there. So if we are going to have a means test, we are going to open up a subject that will keep us all sitting here for a long time.

Ms. Norwalk, you talked about the premium that is going to be paid for the year 2006. I think you said that was fixed for the year 2006?

Ms. NORWALK. May I clarify?

Senator LAUTENBERG. Please.

Ms. NORWALK. The average premium is $32 if you simply took in every single bid that came in from all of the drug plans that want to offer benefits, and you take that and you get an average. Well, the average is $32.20. But as in any average, you have some plans that would be offered at above that and some that would be offered below that average.

Senator LAUTENBERG. What do you think the scaling would be like in 2007 on? Is there any prediction that we would be close to those numbers?

Ms. NORWALK. I do not know that the actuaries have looked at it for the following years. They did in the beginning which they had the average premium going up one year after the next. I think what we are likely to see is, depending on what happens the first 6 months of the benefit, as the drug plans are taking a look at the experience that has come in based on what they have bid now, because many drug plans will be significantly less than even $20,

some less than $10, and how do they do in terms of managing costs?

For many of them, what they do for a living is help manage costs and formularies, and they do things like step therapy or making sure that people are getting generics before brand name drugs, for example. How the companies do individually will obviously greatly impact what the average is for next year, but at least they will have a few months of seeing what the expenditures look like——

Senator LAUTENBERG. But if you had to guess, would you guess that costs could be lower in the years——

Ms. NORWALK. It is possible that they would be lower because the plans that bid higher this year for the standard benefit package would probably not be viable, so may drop out, and consequently, the lower costing plans would stay in.

Senator LAUTENBERG. However, if we look at past experience, we have not seen any decline at all in prescription drug costs as a total, but we have seen the demand go up. And I suspect—and I was excited to hear, Tom, what you said about the prospects for Alzheimer's—if we could find a way to deal with these long-term illnesses, it would be fantastic for people as a whole, but it would also be great on the spending side for our lives.

I think it is fair to say that if one looks out ahead, we are entered into fairly precarious ground about predicting price and costs on these things. So the warranties I do not think—it is a statement but it is not a representation really in terms of the long term.

One of the problems Senator Coburn talked about, and that is the dual-benefit programs, and people are confused about where they go, how they get there. There is a lot of confusion in the material that people are offered. I wonder whether it is not possible for CMS to develop an easy-to-comprehend piece of literature, give them a reference that eases the burden of making—it is very complicated and confusing.

The Government Accountability Office came to the conclusion that the former Medicare head, Tom Scully, broke the law when he prevented an HHS employee from giving cost information about the new Medicare drug program to Congress. GAO directed HHS to recover Scully's salary for this time period, and I am sure that you have heard that. Do you know what steps HHS has taken toward recovery of his salary?

Ms. NORWALK. Well, a couple points to that. I would say, first of all, I am not sure that was the—in fact, I am certain it was not the conclusion of the Office of the Inspector General that also took a look at this issue, at least that is not my recollection.

I do know from remembering reading about it in the *Wall Street Journal* that the *Wall Street Journal* actually wrote an article in September 2003 before this was voted on in either the House or the Senate, that there were significant differences between the Congressional Budget Office and the Office of the Actuary, and it may not have been quite to the tune of $135 or $140 billion, but it was to the tune of, say, $80 billion, certainly enough to put people on notice that there were significant differences between the Congressional Budget Office and the Office of the Actuary. So I am not sure that it was the secret that people seem to think of it now because there was actually a fair amount written about it in advance.

I am not sure what people did ask to specifically look at those different points.

Senator LAUTENBERG. The IG did answer questions when it came to law. That is not his responsibility. But the conclusion given by the Government Accountability Office was that there was an overpayment of some $80,000 for the time that he was on HHS business. But nevertheless, it was not the course of action that HHS chose to follow, and I think it was an unfortunate outcome.

As you know GAO ruled that some of the news stories on the drug benefit were propaganda, considered propaganda. Now, has CMS, HHS stopped producing these VNRs?

Ms. NORWALK. I do not know that we have done any recently. I would say that I think they are an important source of information, but you raise a very good point. At least I have heard you raise it before, which is, it is critical that they be labeled as from the Department of Health and Humans Services, not that it is an important way to get at information as any other press release might be, but it is important to make sure that the people identified are in fact identified as coming from the Department and so on and so forth.

Senator LAUTENBERG. Thanks. Because it is very important that people not be led to believe that this was an interesting news report that came out, but it was a prescribed structured thing that was designed to create a different opinion. And the disclaimer is very important there.

Mr. Chairman, there are lots of things—and I would ask that the record be kept open and Ms. Norwalk be responsive to those questions.

Senator COBURN. Without objection.

Ms. NORWALK. Sure.

Senator LAUTENBERG. I would say this. You raise a very important—the vote is just starting?

Senator COBURN. Yes. We have made arrangements, Senator Carper has gone to vote. He will come back and chair the Committee so we can keep going, so we are respectful of your time. And then I will go vote and then come back.

Senator LAUTENBERG. You raise a critical question about what is the national obligation to provide as much good health as we can to people. I know we certainly try to do it at times of disaster and times of immediate crisis. But it is an important philosophical question. I agree totally with you. When we look at the cost that is passed on to the American people that is not passed on in countries other than ours, where the product is identical and we observe all the costs for research and marketing as well, by the way. So the topic is an appropriate one, and I hope that we will be able to help there.

You know what happens? I am so accustomed to my wife saying, "Frank, quiet." [Laughter.]

Senator COBURN. Ms. Norwalk did not say that, Senator Lautenberg.

Ms. NORWALK. Absolutely not.

Senator LAUTENBERG. Anyway, thanks very much for your testimony.

Senator COBURN. The record will remain open for additional questions. Ms. Norwalk, I have three questions that I will submit, and then I have one last question before I go vote. Remember Medicare Plus Choice?

Ms. NORWALK. Absolutely.

Senator COBURN. Describe for us what happened to Medicare Plus Choice?

Ms. NORWALK. It exists. It is called now—it went through a name change through the Medicare Modernization Act. It is now called Medicare Advantage. We expect that at least two-thirds of all beneficiaries will have access to a Medicare Advantage plan in 2006 that includes zero premiums for drug benefits and zero premiums for their physician benefits.

Senator COBURN. That is a great point. I want you to give the historical representation of what went up and then what went down, why it went up and why it went down.

Ms. NORWALK. Sure. The program initially started in the early 1970s, gained significant numbers of enrollees peaking, in the late 1990s. In 1997 when the Balanced Budget Act passed, they changed the way that Medicare Plus Choice plans were paid in hopes of encouraging them to go into rural areas, and frankly, putting money aside, if you will, to pay those who did show up in rural areas.

Well, the money was put aside but they never came to the rural areas, or very few of them, and so that money went away. Their plan payments plummeted. Consequently, the Medicare Plus Choice plans were trying to figure out how could they, (a) stay in business, (b) keep up their physician and hospital networks, or increase premiums or reduce benefits.

And overall, they lost it, not surprisingly, as that financial pressure continued after 1997, mainly in 1998 and 1999, and we started to see a decline in the enrollment in—I think it is 2001 if I recall—basically because of these reduced benefits and limited networks.

Senator COBURN. Actually what you saw is fewer people wanted to come in and be providers for Medicare Plus Choice because the margin was not there for an insurance or health maintenance organization to survive.

Ms. NORWALK. That is correct.

Senator COBURN. So my question for you is, how do we know that is not going to happen on Medicare Part D?

Ms. NORWALK. I think a couple things are important with that. One of the reasons that we talk about benchmarks in the average premium is because we totally changed the way that we do the plans, that rather than pegging something based on Medicare fee-for-service payments, which is what it used to be in the Medicare Plus Choice program, the Medicare Part D program uses an average of all the plans that come in, and we look to competition to keep that price low because Plan A wants to get more enrollees than its neighboring plan, Plan B.

And in fact, that is what happened with the premiums coming down. That was because, I think personally, of competition.

The payments that way are no longer based or pegged to some Medicare number or whether that goes up or down depending

frankly, on what Congress does. But the drug benefit instead is focused on competition in looking and coming up with averages.

Now, if it turns out, for example, that a plan wanted to charge a premium that was over $32.20, the government is going to continue to pay exactly that same subsidy that it paid, and a beneficiary would pay anything additional. If someone charges less than the average premium, the beneficiary will then pay less. So what happens is the government is paying the same for everyone, and what the beneficiary then pays will depend on the plan they choose, and perhaps it may impact the benefit package.

So rather than having it attached to something in Medicare fee-for-service, it is based on competition, which is why I think it is more sustainable in the long run than the Medicare Plus Choice plan was going forward because of its tie to the—as we call it—the AAPCC.

Senator COBURN. There is probably not anybody more knowledgeable about this issue, and I am sure a lot of people were lost with that explanation. [Laughter.]

Ms. NORWALK. Sorry.

Senator COBURN. I did follow you, and that is fine.

Thank you so much for coming before us. Thank you for the hard work that you are doing.

Ms. NORWALK. Thank you.

Senator COBURN. What we will do is seat the next panel, and Senator Carper will be here. I will run to vote, and Senator Carper will start our next panel.

Ms. NORWALK. Thank you, Mr. Chairman.

[Recess.]

Senator COBURN. We will resume. I apologize. We had two votes, which they did not tell us, and it took that long to get all the Senators to the floor, and I was the first one to vote on the second one, so we will resume.

We have in our next panel Dr. Joe Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute; Dr. Jagadeesh Gokhale, Senior Fellow at the Cato Institute; and Dr. Marilyn Moon, who is the Vice President and Director of Health Program at the American Institutes for Research.

Let me welcome each of you, apologize again for the delay in the time, and your complete statement will be made a part of the record. Try to limit your statement to 5 minutes if you can, but let us do a good job with this.

Dr. Antos.

TESTIMONY OF JOSEPH R. ANTOS, PH.D.,[1] WILSON H. TAYLOR SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE

Mr. ANTOS. Thank you, Mr. Chairman. Passage of the Medicare Prescription Drug, Improvement, and Modernization Act in 2003 marked a major milestone for Medicare. For the first time, all beneficiaries will have access to outpatient prescription drug coverage under Medicare rather than anywhere else. Special low-in-

[1] The prepared statement of Mr. Antos appears in the Appendix on page 53.

come subsidies will be available to needy beneficiaries, and absolutely millions of seniors and disabled people will save money when they buy their medicines under the new program. Those are good things.

All of this comes at a cost. The new program is the largest entitlement expansion since Medicare was established more than four decades ago. The huge sums that the Federal Government will spend through this program will largely be funded out of general tax revenues. That means the new drug benefit was enacted without being fully financed through specifically earmarked funds, and every dollar spent by beneficiaries will add 75 cents to the Federal Government's budget deficit. By adding the new benefit without full funding, Congress has increased the cost pressures that threaten Medicare's stability. So how much money are we talking about?

Now, actually, Mr. Chairman, I think you and the first witness covered this very well, so I will not repeat the numbers except to say that it has seemed, especially this year, that there have been many estimates coming out first from the Administration and then from the Congressional Budget Office, and every time you turn around, the numbers appear to go up. But that is somewhat misleading, as I think the first witness tried to indicate.

In fact, we have not spent the first dollar on prescription drugs for the full drug benefit yet. That means that the actuaries do not have any basis, really, for estimating—or making a new estimate of the cost of the full drug benefit. All that has happened, as the first witness pointed out, is that we have shifted the observation period from a period of 10 years where only 8 of the years involved a vast amount of spending and now it is a full 10 years of the full drug benefit and a lot of money every single year.

That is the reason the numbers seem larger. However, the fact is that this is a program that has no sunset. So the fact that the numbers seem larger is not just an optical illusion. The actual cost of the program could well be much higher even in the next 10 years than either CBO or the Administration estimate. There are all sorts of reasons for that, as laid out in my testimony. One of the most important reasons, however, is what policymakers might choose to do. New legislation, for example, might be considered here on the Hill to make the benefit richer, to fill the doughnut hole, for example, a particularly sore point with a number of Members of Congress.

If that were to happen, that would substantially increase program costs not just for 10 years but forever. In any event, even the most accurate budget estimate, 10-year window estimate, does not tell us how much the program will spend past 2015. The amount is stupendous. The Medicare trustees estimate that Part D spending net of beneficiary premiums and State payments—that is the so-called clawback—will total about $8.7 trillion over the next 75 years. That is measured in present value terms.

Now, that is the amount of money that must be transferred from general tax revenues over the next 75 years to pay the full cost of Part D. That is a very large amount of money. That is well over the $725 billion over the next 10 years estimated by OMB or the $850 billion from CBO. And while that is a long-term projection

rather than a known fact, it still tells us the direction of this program.

The direction clearly is to make a huge commitment of our Nation's resources to this benefit. However, the drug benefit by itself is not the whole story. Medicare Parts A and B also are underfunded. As you mentioned with the first witness, Part A is reasonably well funded, but that will change. Part B is not.

So what can we do? We cannot expect the economy to grow our way out of this. The Congressional Budget Office, in a report several years old, indicated that if you look at all of the major entitlement programs oriented to the elderly—that is, Medicare, Medicaid, and Social Security—by 2030 we could be spending 17.4 percent of GDP on those programs. That is a lot of money. CBO says that is an unsustainable level of spending.

We could raise taxes. If we raise taxes, however, that cuts into our economy's ability to grow. My colleague at the Heritage Foundation Tracy Foertsch and I did an estimate of that impact. We have looked at what the economic effects would be if we were to fully finance Medicare A, B, and D for the next 10 years. That is just 10 years of full funding. If we do that, then we will have a serious impact on the economy. GDP will fall by an average of $87 billion a year. Employment will drop by an average of 816,000 jobs per year. That is really serious.

We need to do something about Medicare, but growing our way out of it is not the answer. It will help. Taxing our way out of it is not the answer. We probably will increase taxes. What we have to do is look at the incentives that are driving the costs in the program.

I have a lot to say about that in the written testimony, but the bottom line here is that we have made promises that we cannot keep, and I believe it is incumbent on Congress to look carefully at those incentives that are driving Medicare spending today and will drive Medicare spending tomorrow. Thank you.

Senator COBURN. Dr. Moon, I am going to ask you to go next, if you would.

TESTIMONY OF MARILYN MOON,[1] VICE PRESIDENT AND DIRECTOR, HEALTH PROGRAM, AMERICAN INSTITUTES FOR RESEARCH

Ms. MOON. Thank you very much, Mr. Chairman. It is a pleasure to be here, and I thank you for the invitation.

For 40 years, Medicare has provided nearly universal coverage to a vulnerable population, changed with the times, and done a better job of constraining costs than has the private sector for much of that period. From the perspective of Medicare beneficiaries, the goal of changes in Medicare should be to seek genuine efficiencies in the delivery of medical care, to assure access to care for this population, particularly those with limited resources, and to find an equitable way to finance the program over time.

While concerns about the costs of Medicare are important, it is also the case that Medicare cannot function well if it is inappropriately restricted. The new prescription drug benefit—although lim-

[1] The prepared statement of Ms. Moon appears in the Appendix on page 62.

ited in its comprehensiveness—is an important addition that is essential to assuring access to good health care. No one would imagine today starting a new health care insurance program without prescription drug coverage, for example, as Medicare was in 1965. But it is important to find the right balance of benefits, access, and sources of financing.

I make several points in my testimony today that I am just going to briefly summarize here.

First, historically, Medicare has done as well or better in holding down the costs of care as has the private insurance system, and I think that was indicated earlier when others talked about the costs of health care. They are going up everywhere. It is a problem throughout the system—or it is an issue throughout the system, I should say. We should be concerned about the problems that are created when health care grows rapidly and whether or not it is necessary to do so. But I would also point out that we have gotten a lot out of the very positive effects of changes in health care in recent times.

Second, improvements in the efficiency and appropriateness of care can help to reduce costs, but will not be enough to avoid a need for greater financing from Medicare over time. People are often looking for the magic bullet to avoid having to pay more. It simply is not out there. It would be nice if, for example, a change in the delivery system by itself would suddenly reduce health costs substantially. Others would like to pass costs off onto beneficiaries and solve the problem that way. Actually, passing the costs off onto beneficiaries is not a way of saving society money. It is simply a way of saving the government money. It is effectively a form of financing. It is implicitly a way to finance the program by asking beneficiaries to pay more either through higher premiums or a higher age of eligibility, for example.

In addition, it is often thought to be a magic bullet to income-relate the program. I wish that all Americans over the age of 65 and those with disabilities were wealthy enough that income-relating was a viable option and could solve the problem on its own. But over half of seniors in the United States have incomes of less than $25,000 a year, and they are simply not well off enough to be able to fund a substantial additional amount out of their own pockets. Already, individuals over the age of 65 pay more for their health care, not counting long-term care, than they did before Medicare came into being in 1965. Just as the Federal Government and other health care payers have been affected by higher health care costs over time, so have seniors who pay for, on average, about 45 percent of the costs of their own care.

Medicare pays only about 55 percent of the costs of the care. Either individuals pay or someone else pays on their behalf. And in the case of the Medicare program itself, it is split such that about 70 percent of the costs of Medicare are paid by the Federal Government and about 30 percent are paid by beneficiaries out of premiums and out of taxes they pay.

So one of the important lessons is not to overstate what is possible to get out of seniors over time, although we certainly should look at who could and should pay for this program over time. A better way to think about Medicare is to assess who is best able

to pay for the care. This is something that will need to be looked at periodically over time. It is very difficult to know, for example, whether future beneficiaries will be substantially better off as compared to future workers.

If you look at the Actuary's estimates from the most recent Board of Trustees Report, you will find that per worker GDP—that is, a measure of how well off people will be after controlling for inflation—will increase by approximately 66 percent into the future. If you assume there would be no savings from Medicare from any changes, which I do not believe we will allow to happen, the Medicare burden on workers would lower per capita GDP, but still leave workers 57 percent better off than they are today, even after controlling for inflation.

It is going to be a tough challenge to look into the future and decide how to balance who should pay, but that one of the important things to remember is that Medicare has been a successful program and that seniors and persons with disability need to have this program continue. Thank you.

Senator COBURN. Thank you very much. Dr. Gokhale.

TESTIMONY OF JAGADEESH GOKHALE,[1] SENIOR FELLOW, CATO INSTITUTE

Mr. GOKHALE. Chairman Coburn, Senator Carper, thank you for the opportunity to testify at this hearing. I am quite honored by it.

Senator Lautenberg reflected earlier that the extent to which the National Government should assist people in spending healthier lives and improving their health is a philosophical question. He did not answer that question, but economists have a definite answer to the question regarding the extent to which the Federal Government should be involved in any particular activity, and that answer is market failure. If there is a clearly perceived market failure, then government intervention is justified.

We know that the vast majority of seniors have prescription drug coverage. The numbers that I have seen suggest that up to 90 percent of them have access to prescription drugs—which does not indicate a clear market failure. Indeed, I believe that implementing this law as is will *cause* market failure and will displace the private provision of prescription drug insurance for retirees. It will also displace and worsen the quality of prescription drug insurance provision for non-retirees as well.

This law will improve access to prescription drugs for low-income retirees, both those who are and those who are not currently covered under Medicaid. Upper-income retirees and those with high drug expenses will also benefit substantially. But some retirees may experience higher out-of-pocket costs and worse quality of coverage if employers and other providers reduce or withdraw their higher-quality retiree supplemental plans over time.

So MMA, therefore, appears to be designed to displace first private drug coverage in the insurance market, and that will be followed, I anticipate, by sustained pressure in Congress to further liberalize the law that is on the books today.

[1] The prepared statement of Mr. Gokhale appears in the Appendix on page 77.

The difficulties of improving the operation of prescription drug and drug insurance markets are well known. But this program is actually likely to worsen the performance of those markets.

Theoretical reasoning and empirical studies suggest that private drug prices would increase following the entry of a large number of additional government-subsidized patients. Existing patients would increase their demand for drugs because of the additional subsidy. Doctors will also prescribe more drug therapies as a result of people having access to more generous drug insurance.

Most of the burden of drug price increases will fall on workers because employer provision of health insurance to workers will become more expensive as drug prices increase. That will have adverse effects on labor markets.

The drug law represents a very large addition to the already considerable financial shortfall faced by the rest of the Medicare program. Unresolved, this shortfall will grow larger and impose higher fiscal burdens on future generations, erode economic productivity, and decrease the growth of national output. I think very few people are really appreciative of how huge an addition to Medicare's unfunded obligations this program represents and the adverse impact those obligations will have on other sectors and the economy as a whole.

Finally, the Medicare Modernization Act will change workers' and younger generations' perceptions of how much they should save for their own future health care needs. Studies have shown that an expansion of Federal entitlement obligations increases consumption and reduces national saving and investment, and that would cause a further negative impact. So there are three tiers of negative impact that the economy will experience: first, worse health coverage for workers; second, higher tax burdens to finance this additional entitlement obligation; and, third, reduced savings that will reduce our investment and capital formation and, therefore, reduce worker productivity going forward. That will have a negative effect on future output.

This law was passed rather hastily. The program lacks appropriate controls against spending escalations. That means future Congresses may be induced to regulate the actions of various players—pharmacies, drug manufacturers, employers, plan providers, and so on. And those regulations will have counterproductive effects. They may reduce or cause drug supplies to be restricted. They may induce illegal drug sales and worsen the quality of doing insurance for everybody in the economy.

So my recommendation really would be to repeal this law. But if doing so is impractical, I would certainly recommend downsizing it to cover only low-income retirees, those with inadequate drug insurance, and those with high drug costs. And that would be, I think, a financially and economically sensible course to follow.

I think I will stop there and welcome your questions. Thank you again.

Senator COBURN. Thank you very much. Right now I want to call on my Ranking Member, Senator Carper.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Thanks very much. I think I can withhold any kind of statement now and just maybe I could ask some questions. Thanks very much.

To our witnesses, thanks a whole lot for being here. I apologize for missing the testimonies of several of you. We have votes on the floor, trying to get a military construction appropriation bill passed, and I have some input there. And I had another committee I was testifying before, so I apologize. I am usually a better, more attentive Ranking Member than I have been this afternoon.

Let me just start off, if I could, by asking each of you maybe to comment on some of the reasons why you believe that health care costs in general are rising, not just in Medicare but in general, some of the reasons why you think that is happening, and maybe you could share with us a couple of useful tools that you think might be out there for us to constrain the growth of those costs.

Mr. ANTOS. Well, let me start, Senator. I think perhaps the most important factor that is driving health care costs in general has to do with the very nature of health insurance. Health insurance by its nature subsidizes people. They don't pay out of pocket for the full cost of their care.

In this country, as we all know, for the last 50 years or so, we have had a very generous tax break for employer-sponsored coverage. So most people get their health insurance through employers. I can speak personally on this. They are not very much aware of what the full premium is that is being paid for directly out of their pay and partially on their behalf by their employers. So we are unaware of that. We are also unaware of the real cost of an office visit, a prescription drug, or any of the other medical interventions that might be before us. So we are cost-unconscious. This is one of the rare sectors in our economy where people buy things without knowing what they cost and only finding out later.

That has to be driving a lot of the cost. If people were more aware, for those things that are optional—not those services that you can't avoid, but for those things that are optional, people would think, Do I really want this? And in particular, in the case of prescription drugs, people would be incented and they are increasingly incented to think about generic drugs rather than the brand name equivalent.

Senator CARPER. Thank you. Dr. Gokhale.

Mr. GOKHALE. I agree that there is a tremendous amount of government involvement in the health care market. Low-income individuals have government subsidies. Employees have government subsidies through a tax deduction for employer-provided insurance. And retirees have government subsidies. Pretty much everybody in the economy is affected by government subsidies. This third-party payment system that we have established makes people insensitive to the cost of the health care they are consuming. And insensitivity to the price means people are going to demand health care even if the benefit is very slight. Health care services are consumed for the most minor illnesses, when they are probably not needed. For example, if I have the flu, I would run to the doctor because it is easier to take care of it that way if it doesn't cost me anything.

This is especially true for prescription drugs. Prescription drug prices have been growing three times as fast as health care costs have been growing in general, and that is because there is a shift in emphasis on——

Senator CARPER. Is that when we include generics as well as non-generics?

Mr. GOKHALE. I am talking about all prescription drugs. That is because there is more emphasis now on drug therapies, so the demand for drugs is rising. Doctors are prescribing drugs more frequently. So, obviously, the pressure of rising demand for drug therapies that are easy to administer is escalating faster.

Ms. MOON. I have a different view than my colleagues. Although we are all economists, everyone sees this a little bit differently. I do believe that there are a lot of market failures in health care, partially because of very poor information. It is very difficult for individuals to know what care is necessary and what is not necessary. And although I do think that, at the margin, people are using extra services, I personally do not know many who say, "I would like to run to the doctor today. I am a little bored and it is going to be free," or "I am feeling a little blue, so perhaps I will get knee replacement surgery and I will move around a little better."

In terms of the large expenditures, I do not believe overuse is a major issue. The major issue is that individuals right now, without information about quality, necessity and effectiveness, see that the way to protect themselves is to overuse services to a certain extent, to ask for extra tests if there are things that are uncertain, to go to a different doctor if they are not finding what they want from the first doctor. We could do a lot better with information and educating the public that sometimes more is not better. That would be one thing that would help substantially, but I don't think we should kid ourselves. We are getting a lot from the health care system. Our lives have improved. Our health status has improved. And most Americans are willing to pay a lot, and I don't think we have seen the end of what Americans are willing to pay for health care.

Even in the case of prescription drugs, which is much less well covered for seniors than are other aspects of their health spending, they use drugs just as fast as they use hospitalization. We need better information for consumers, but it is going to be very difficult to wrestle this tiger to the ground.

Senator CARPER. I have some more questions, but let me wait for the second round. Thanks, Mr. Chairman.

Senator COBURN. Do any of you know any government program where the estimated costs went down versus what they were estimated when they first started?

Ms. MOON. Medicare. When we adopted the relative value scale for physician services——

Senator COBURN. No, I said when they were first started.

Ms. MOON. When they were first started?

Senator COBURN. Yes. When Medicare was first started, their first year, their second year, they weren't anywhere close on the estimate. Relative value scale, there is no question it did better than what they thought. But I am talking about government programs—

do you know of any government programs that had an estimated cost that are mandatory or entitlement programs that cost less than what they were estimated at the initial onset of them? Does anybody know one? I don't. I just thought there might be one out there.

What is the debate in Germany today? Forty percent of their GDP is consumed by the government programs, right? They have an unemployment rate of 12 percent, they have a tax rate twice ours, and they have a stagnant economy. How do we not get there with this program and others?

Mr. GOKHALE. There was a study done by Edward Prescott, who is the latest Nobel Laureate in economics, which compared the U.S. and Europe now versus in the 1970s. Both countries have essentially the same technologies, so productivity per worker is pretty much the same, has been the same in the 1970s and is the same today. But in the 1970s, tax rates, marginal tax rates in the U.S. compared to those in European countries on average were similar. And so hourly work rates for workers were also similar. Therefore, output levels per capita and living standards per capita were similar across the two countries in the 1970s.

Today, however, because a much higher fraction of workers' earnings are taxed to support the entitlement system—much more generous entitlement system in Germany and other European countries—those high tax rates mean there is less work effort by those who work, and workers prefer to take more vacations. There is more unemployment. There is less flexibility in the labor force as a result. Although productivity per worker is the same between the U.S. and Europe (because the technology available to both areas is the same), output per capita in Europe is much lower because of lower work effort.

Therefore, living standards in Europe are only about 80 percent as high as those in the United States. So high tax rates to finance entitlement obligations that will not over time, will surely make the U.S. economy more similar to that of European countries in the future if the current laws are continued and the fiscal shortfalls that the country faces remain unrsolved.

Senator COBURN. OK. Well, that is my view. I have studied what has happened in Europe in terms of the percentage of GDP that has been consumed by the government and the drag it is on the economic progress, which inhibits growth, which inhibits all that.

Dr. Moon, what is your solution? How do we fix this? Do you have a solution for us? How do we take this $29.7 trillion unfunded liability over the next 75 years. How do we handle that and not kill our economy or lower the standard of living? How are we going to do that? Do you have any suggestions for us?

Ms. MOON. One of the things that we should continue to do is to seek ways to improve the efficiency of the Medicare system. For example, the changes that occurred in 1997 with the Balanced Budget Act served to lower substantially the projections for the future, and, in fact, even with the addition of the prescription drug benefit, the actuaries are not projecting that Medicare spending will reach the same level in 2025 as they had projected in 1997.

So there are things that can be done gradually over time that are effective. I think it is——

Senator COBURN. Do you see a requirement by the government making it mandatory that physicians care for Medicare patients?

Ms. MOON. I would hope not. I would hope that this continues to be a voluntary program. What it means, if we are to keep it voluntary, is that Medicare will have to pay at a reasonable level as compared to what other parts of the health care system pay physicians for health care.

Senator COBURN. But they don't, do they?

Ms. MOON. Actually, physicians' payments now are pretty comparable to what a lot of private insurers pay. In some places the level is higher, some places it is lower—not so much because Medicare has gotten more generous, but because the rest of the system has gotten a little tighter.

Senator COBURN. Do you have a reference for me for that?

Ms. MOON. MedPAC, the Medicare Payment——

Senator COBURN. MedPAC study?

Ms. MOON. Yes.

Senator COBURN. OK. What I hear continually from providers is not next year, and that is what we are seeing, is the providers, they can't—what used to happen—and that is why I took issue with one of your other statements. This is a cost-shifting program, and in your statement you are denying that it is a cost-shifting program. And what used to cover for covering the differential in Medicare in terms of providers and hospitals was the fact that they had this other private sector out there that paid a higher premium, and that was cost shifted and there was not a problem.

As we have held down Medicare and as the other costs of health care have risen, then that ability to cross-subsidize, I believe, has lessened, and that is why you are starting to see people wanting to move away from it.

The real question I guess I would come back and ask you is: How do we fix the costs in health care? Because we are never going to fix Medicare until we change the incentives. And I loved what you said about markets. There is no market transparency in health care. Would you agree?

Ms. MOON. Yes.

Senator COBURN. And so we are never going to be able to use market forces unless there is market transparency in terms of price, quality, outcome, and availability. Would you agree with that? Would everybody agree with that?

Ms. MOON. Yes.

Mr. ANTOS. Yes.

Mr. GOKHALE. Yes.

Senator COBURN. So is that one of our solutions, to create market transparency to help create competition?

Ms. MOON. To some extent, although this is a market in which I do not believe that price works as well as in a lot of markets. When someone becomes very ill, which is where most of the health care spending occurs, on average, they are not going to be very price-sensitive. They are going to want the care that they need for their loved ones.

Senator COBURN. But you do not believe, if there is a quality indicator in the market and I become ill and a price indicator, that even though it may be a major illness, I will not have the capa-

bility through my family or myself to make a value judgment on that. I will go to get the care and not consider price and outcome. Is that your testimony?

Ms. MOON. No. I think that there is a little bit of sensitivity to price and a lot of sensitivity to outcome if people know what it is.

Senator COBURN. They don't know, though, right?

Ms. MOON. They don't know very well.

Senator COBURN. That is right.

Ms. MOON. But I really do not believe that most people are inhibited, for example, if they are told that their family member needs an operation, they are going to try to get it. If they can get someone to help them pay for it, of course, they will. But I do not believe that it is very much of a deterrent to health care spending, nor do I think it should be when we are talking about really serious illnesses.

Senator COBURN. Do you remember when we used to have forced second opinions in health care?

Ms. MOON. Yes.

Senator COBURN. What did that show?

Ms. MOON. What it largely showed is that a second opinion that was different just confused people and they didn't quite know what to do with that. We are in a much better position now to take advantage of a lot of information that is out there. We need a lot of sorting out of the quality of that information and some feeling on the part of individuals that they are getting credible information. But we are a lot closer to being able to have good information than we were.

Senator COBURN. I do, too. Thank you. Senator Carper.

Senator CARPER. Thank you, Mr. Chairman.

I am torn as to which way to go with a question or two. First let me make a comment. I voted for the Medicare prescription drug bill, not because I was deeply enamored with it, but we were sitting around in my office with my senior advisers and asking, Well, what is your advice? It was literally almost time to vote, and I had been wrestling with this for some time. And most everybody around the table said the politically smart thing to do would be to vote no. If it becomes law, people who wanted it to become law won't be mad at you because, even though you voted no, they will still get the benefit. And the people who wanted you to vote no, they will be glad you did even though the measure was approved.

And I said, well, all well and good to give me political advice. Just tell me what you think is the right thing to do. And I will never forget one of the fellows, one of my allies, who is now gone, one of my legislative aides who is now gone, he said, "I think the right thing to do is to go ahead and vote for it. This is a flawed program, but we need to get started somewhere. There are a lot of things we can do with pharmaceuticals today that we could not do 40 years ago when Medicare was introduced. And for a lot of people around the country who don't have anything at all, for a lot of people who are really poor who don't have any kind of coverage at all, for a lot of people who have very high, very expensive drug costs and prescription costs, this is a pretty good benefit."

And in the end, I was persuaded to vote for it, and I have not regretted it, at least not yet.

I missed the part of the conversation where you all talked about means testing. I think it was Part B of Medicare, which is something I support. I think the Chairman does as well. I see in the Medicare Part D program that it is means tested to some extent. If you happen to be poor, you do not pay the monthly premium. If you happen to be poor, you do not pay the deductible. If you happen to be poor, you do not—there is not much of a doughnut hole there. If you happen to be poor, you get a pretty good benefit. If you happen to have huge out-of-pocket drug costs of $1,000 a month or so, I mean, it is a pretty good benefit.

So it is really a program that is, I think, most beneficial to people who are poor and folks who have really catastrophic needs. If you happen to be middle class and you do not have huge prescription drug needs or you happen to be wealthy and you do not have large prescription drug needs, it is not a great program. For folks who have something that they like that is reasonably good, I basically say to them in Delaware, "You should probably just keep doing what you are doing, using what you are using, until you lose it, and then you may want to consider this."

There was a very good cover story, I think it was *Business Week,* a couple of weeks ago where they talked about the new generation of pharmaceuticals that are being developed, which are designed to take advantage of our ability to map the human genome and to develop almost like personalized drugs. We have a pharmaceutical company in Delaware, AstraZeneca, that has developed a drug—it starts with an "I." I can never remember the name of it. It is something like "intressa" or something like that. And they have come up with this drug, and they found—it is weird. They found that people in Asia—it is a cancer, an oncology drug. They found that people in Asia who are treated with this drug do reasonably well, but folks, maybe in the United States or in Europe, don't. They had a hard time figuring out why for a couple years, and I think they finally figured out it has something to do with the DNA or the genetic makeup of some of the folks in Asia who are benefited by this drug is maybe different somehow than we are. I will leave it to the doctors on this Committee to figure out why that is the case.

But I make the point just to say that we can do so much more with pharmaceuticals today than we could 40 years ago when Medicare was introduced, and I think that argues for our benefit. I think as work goes on by large and small pharmaceutical companies in this country, they are going to be able to develop medicines that are almost like designer drugs, in the best sense of the word, designer drugs for us to help us. And we may have as many blockbuster drugs, but we are going to have more drugs that are particularly good for me or for Dr. Coburn or for Dr. Moon or anyone else in this room. So I am rather encouraged by that.

There is more I would like to say, but I am going to maybe offer a statement for the record. But let me just ask a question, another question, if I could.

Senator COBURN. We have agreed to leave the record open for a period of time.

Senator CARPER. That is great. Thanks. Thanks very much.

What I want to ask you to do is help us look at the VA system for just a little bit. I was a naval flight officer back in the Vietnam

War. I remember coming back from Southeast Asia, getting out of the Navy in California, and just moving over to Delaware and going to get an MBA at the University of Delaware. And almost the same day I enrolled at the U of D, I went to the VA hospital about 15 miles down the road and signed up for, oh, gosh, whatever benefits I was eligible for, including the GI bill.

I remember getting some dental work done there. I found out that I could get a physical and that sort of thing, and for a year or two I could get some medical care at that hospital.

At the time, I remember talking to the providers. People were not anxious to be doctors or dentists or nurses at that VA hospital. They were not anxious to be doctors or dentists or nurses in the VA system, and it was not the place—it was like a backwater rather than a cutting-edge sort of place to practice business.

Boy, that has changed in the last 10 years, in really more in the last 5 years, but really over the last 10 years. And they are doing something right there.

One of the things they seem to be doing is harnessing the information technology in ways that makes them more productive. If you go to the VA, you have an electronic health record. They use that and a lot of other tools in a real smart way to provide better health care, better outcomes. They have been able to reduce the level of employment within the VA system. They have taken a whole boatload of new patients because of the war in Afghanistan and Iraq. And it is really rather remarkable that the backwater that nobody wanted to work in when I first came out of the Navy is a place where people actually think it is a neat place to work and to get care.

Let me just ask you if there are any implications there for us from the VA system. If you would, don't take a long time but just give us some thoughts, if you would. It is not exactly the free enterprise system, but something good is going on there.

Mr. ANTOS. A lot of good is going on there. They have certain advantages over the rest of the health care system in the sense that everybody is an employee. So the doctors adhere strictly to the formulary. It is more than a formulary. You are going to prescribe drug X for condition Y, that is it. That is a great advantage, especially if your patients will respond properly to drug X. Presumably they have some safety valve there, but, by and large, there is strict adherence to the formulary. You don't see this anywhere else.

As far as information management is concerned, absolutely, they are way ahead of everybody else now. But, again, the advantage is that they are buying the computers, they are putting the software in, and everybody is doing the same thing.

Maybe we do not have to make everybody do the same thing, but there is a strong sense that I have that HHS in particular should begin to take an initiative about not just saying, well, let's get together and talk about it, but let's decide what the electronic standards are, let's decide what the minimum data set is, not the maximal data set. If we can do that on electronic health records, then we could let the private sector go ahead and develop the products more appropriately. But we have to take that first step, and honestly I don't see anybody else doing it. I really think it is the job of the government to make that step.

Senator CARPER. All right. Thanks. Dr. Gokhale.

Mr. GOKHALE. I imagine there is going to be a fairly steep and long learning curve before people trained in medicine, non-information technology disciplines, who already bear a huge burden about being good at their fundamental profession, to then adopt new technology when they are not used to it—haven't done it ever before—to streamline all their information flow, keep their patient records, do proper diagnostics, and provide the information in a streamlined way so that it can be used in a high-tech manner, stored in a high-tech manner, and retrieved in a high-tech manner by those who need it.

Getting all of that together is going to take some learning and take a lot of adjustments. I don't think it is a short-term solution. Health care costs are rising much faster than the cost reduction that the adoption of this kind of technology-intensive approach can bring about. So I think that it is a good idea, a good approach, but it is going to take time.

Senator CARPER. All right. Thank you. Dr. Moon.

Ms. MOON. The VA system is in some ways like a very well run coordinated care system that, first of all, looks at the whole of the treatment of people, which is a very good idea.

But, in addition, the VA brought in respected people who had a lot of knowledge and were really pushing to be on the frontiers of knowledge. That develops a trust so that people will comply if they think things are being done for a good reason. And, in particular, their drug formulary is based not just on the best price they can get from a particular drug manufacturer but, rather, on studies of equivalence and which drugs work the best, with some ability then to recognize that not everything works the same way for every person.

Senator CARPER. Mr. Chairman, thanks for being generous with the time. I realize we face these huge cost concerns with respect to Medicare, and with the addition of Part D, it does not make it any easier.

Having said that, this is one of those deals where I think the glass is also half-full, and I was a supporter of health savings accounts—my guess is you may have been as well—and the kind of consumer-directed health care that I think it helps to foster. I am encouraged by these developments with respect to drugs that are more like designer drugs where they can actually figure out what our genetic makeup is and which ones might work better for particular people than others.

I am encouraged by the work that—and it is not just the work they have done at the VA, although they are a good example of how we can get a little more productivity out of a health care delivery system by harnessing IT, just like we got more productivity out of the rest of our economy back in the 1990s, with the exception of health care maybe.

I am going to walk out of here and go catch a train, but this is something I am really interested in. I am not a doctor, but I am still really interested in it. I think it is just hugely important for our country because—I will close with this. I was talking with Rick Wagner the other day, who is the chairman of GM, and we were talking about health care costs, trying to compete with the rest of

the world. And the folks in the auto industry used to say, "We spend as much money for our health care costs as we spend for the steel that goes into our cars, trucks, and vans." And then it became, "We spend more money for health care costs than we do for the steel that goes into our cars, trucks, and vans." Now our friends at GM tell us that they spend more money for health care costs than they spend on all the capital investment they make throughout the world, and they have to compete against companies that don't have health care costs even close to that.

One of the things I suggested to him—I will say this and stop. But there is some interesting work being done at a consortium of high-tech companies. Sysco is one of them. I think Intel and Oracle are other ones. And I have drawn them to GM's attention and more recently to DaimlerChrysler. And what they have sought to do with that consortium of three high-tech companies is to find ways to use—in pricing and reimbursing health care costs, to provide us to do a better job, and who also use IT, have captured IT.

And so there is—this glass is half-full, and I think maybe one of the things we can do with our Subcommittee, Mr. Chairman, is find ways to put a spotlight on the stuff that we are doing well, just like we are trying to do with Katrina, put a spotlight on the stuff that we are doing well, that actually holds down health care cost growth and provides some better outcomes.

Thank you, and to our panel, thanks so much. I am going to go see my 17-year-old son inducted into the national—not the national—I started to say the national hall of fame—the National Honor Society at a charter school in Wilmington.

Senator COBURN. Thank you, Senator, and thank you for making it back after the vote. I appreciate that.

I just have a few other questions, and then I would like to have the opportunity to submit questions to each of you, if you would answer them in writing. There will be about three or four.

Dr. Moon, you reference on page 5 of your testimony, "Medicare currently covers only 55 percent of the acute health care costs of its beneficiaries." Where does that number come from?

Ms. MOON. That number is fairly consistently reported in a number of places, but the most recent numbers that I had were from the Administration, from CMS.

Senator COBURN. Would you be kind enough to send us the reference for that number?

Ms. MOON. Sure, I would be happy to.

Senator COBURN. I have one other question I want to ask, and I am asking this as a provocative question because I can tell you, I am absolutely on the other side of it. And I believe the reason we are having problems today is only 53 percent of our market, even though it is a non-visible, non-transparent market, is private and 47 percent is public. Should we just go onto a single-payer system? What are your thoughts? And ration care? Because that is what everybody else in the world has done.

Mr. ANTOS. As my mother used to say, just because the kid down the street does it, doesn't mean you can. She was right.

All systems ration care. We basically have a choice to make, and we have not quite made the choice. You can either have a government entity or an expert decide what is—kind of make the value

judgment, what is right for you. Or you can try the market system, which we are struggling with right now in this country. You can try the market system and, in the absence of market failures, you would have people more personally deciding what level of health care they need as patients, but I agree with Marilyn on the problems. I do not think anybody would disagree with Marilyn's initial statement that lack of information is a big factor. That is one of the market failures. We do not have a Consumer's Report for health care, or if we do in CMS, nobody can understand it.

So we have a choice there. If we go the route of Europe, we will go the route of Europe economically as well. We will have a smaller economy. We will be able to consume less of everything else. But we are going to have to make a decision.

Ultimately, there are scarce resources. Nothing is free, including health care, in spite of our institutions that lead many of us to believe that it is almost free.

Mr. GOKHALE. I agree with Joe's comments. I would add that there is a lack of information transparency right now. But we do not have a free market. We have a market in which the government intervenes considerably. The current system provides very little incentive for people to actually seek out health care options and information. They do not have the incentive because someone else pays for their health services. They do not have the incentive because their own resources are not at stake.

One good feature of the current law that was introduced, Medicare Part D, was setting up Health Savings Accounts, which would encourage workers to put away some funds for their own future health care needs and they would get a tax break for it. That is a step in the right direction. I think that feature of the law should be expanded. And you would see, I think, that it will go a long way towards promoting greater transparency and market information.

Although many think that the market is failing in the information and transparency area, it is mostly because we are not letting it operate properly.

Senator COBURN. Dr. Moon.

Ms. MOON. I believe that we could have a well-functioning universal single-payer system in the United States, but it would be difficult to do. It would be difficult to do with the kind of philosophy and culture of the United States where we value the ability to be very independent and to do things a little differently than other people. By its nature, it is very important in a universal system to have a lot of standardization and equality, and that is one thing that a lot of Americans do not want. They want to do things their own way. So I think our culture would make it difficult to do so.

I don't think that it means that inherently a universal system is bad or inappropriate. In fact, I think it could be more efficient, but it is not something that Americans are willing to do.

Other societies that do well with a universal system have much more of a communitarian viewpoint, and it does have its downsides as well. Thus, we are better situated to consider how much of a floor of care and coverage we want to have. This is the key issue to talk about now so that no one totally falls through the cracks.

Senator COBURN. I agree with that. My own personal philosophy is that we cannot keep doing what we are doing, because I think we have cost drivers because of what we are doing, a pseudo-market that is really controlled and influenced by the Federal Government making people make poor economic decisions—not just patients. I am talking provider groups, the whole works throughout it. And so I don't think we can keep doing it. I think we either have to go to a single-payer system or we have to go to a real market. And I am inclined to want to create a market, a real market, what an economist would say is a real market, where there is an evaluation of value based on price transparency, quality transparency, and output transparency, with the purchaser of the health care with some skin in the game.

And that does not forego the fact that you can have that floor, and I think we can afford the floor even more, I believe, if we go that way. And there are some good studies like on best practices. That is one of the things VA has done. But if you incentivize best practices, you cut costs. And we have seen that in two or three pilot projects now that are working. One is getting ready to start for Medicare, where you pay the doctors more if they follow the best practice parameters of the University of Vanderbilt and Duke and Utah and follow that. And what happens is you get less overutilization by the physicians, and you also incentivize the information RX coming back to the patient so they get a break. In other words, there is an incentive for the patient to do what the doctor says to do based on what the known best practice is in the country. And it also helps us on our liability because now you are not shooting into the dark to protect yourself. You have got the best in the country recommended at this time, here is the best way to do that. And so we can either mandate, like we do in the VA, here is the way you will do it, or we can incentivize it and see if we can get creativity.

The only thing I would say if we go to a single-payer system, 80 percent of the world's innovation in health care will dry up because that occurs here. And the only reason it occurs here today is because there is still a pretty big market that is private, even though we don't call it a market. An economist would say it is not a very good market. There is still a way to follow what my economists taught me, which was greed conquers all technological difficulty. And my economists said, if you have that capability, then you will accomplish the technical things.

So I would hope that if you have additional ideas in terms of health care, whether it be expanding the VA system—because there is not going to be one system that fits all, and there is not going to be a perfect market developed. I understand that. But there are ideas that are good out there that we can use, and we are going to have to do something because we cannot take $29.7 trillion and heap it on our kids. And that is just Medicare. That is not Part B of Medicare. That doesn't include Medicaid, and that doesn't include Social Security.

So we are on an unsustainable path, and we need every good idea from every viewpoint to try to solve the problem.

I appreciate your consideration and spending extra time with us today. I do apologize about the vote, and I am sorry that you are

still here. I thank you for your testimony, and I look forward to your written responses.

Thank you. The hearing is adjourned.

[Whereupon, at 4:52 p.m., the Subcommittee was adjourned.]

APPENDIX

Table III.B4.—Operations of the HI Trust Fund during Calendar Years 1970-2014

[In billions]

	Income								Expenditures			Trust fund	
Calendar year	Payroll taxes	Income from taxation of benefits	Railroad Retirement account transfers	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other[1,2]	Total	Benefit payments[2,3]	Administrative expenses[4]	Total	Net change	Fund at end of year
Historical data:													
1970	$4.9	—	$0.1	$0.9	—	$0.0	$0.2	$6.0	$5.1	$0.2	$5.3	$0.7	$3.2
1975	11.5	—	0.1	0.6	$0.0	0.0	0.7	13.0	11.3	0.3	11.6	1.4	10.5
1980	23.8	—	0.2	0.7	0.0	0.1	1.1	26.1	25.1	0.5	25.6	0.5	13.7
1985	47.6	—	0.4	0.8	0.0	–0.7[5]	3.4	51.4	47.6	0.8	48.4	4.8[6]	20.5
1990	72.0	—	0.4	0.4	0.1	–1.0[7]	8.5	80.4	66.2	0.8	67.0	13.4	98.9
1995	98.4	$3.9	0.4	0.5	1.0	0.1	10.8	115.0	116.4	1.2	117.6	–2.6	130.3
1996	110.6	4.1	0.4	0.4	1.2	–2.3[8]	10.2	124.6	128.6	1.3	129.9	–5.3	124.9
1997	114.7	3.6	0.4	0.5	1.3	0.1	9.6	130.2	137.8	1.7	139.5	–9.3	115.6
1998	124.3	5.1	0.4	0.0	1.3	0.1	9.3	140.5	134.0[9]	1.8	135.8	4.8	120.4
1999	132.3	6.6	0.4	0.7	1.4	0.1	10.1	151.6	128.8[8]	1.9	130.6	21.0	141.4
2000	144.4	8.8	0.5	0.5	1.4	0.0	11.7	167.2	128.5[9]	2.6	131.1	36.1	177.5
2001	152.0	7.5	0.5	0.5	1.4	–1.2[10]	14.0	174.6	141.2[9]	2.2	143.4	31.3	208.7
2002	152.7	8.3	0.4	0.4	1.6	0.0	15.1	178.6	149.9[9]	2.6	152.5	26.1	234.8
2003	149.2	8.3	0.4	0.4	1.6	0.0	15.8	175.8	152.1[9]	2.5	154.6	21.2	256.0
2004	156.5	8.6	0.4	0.4	1.9	0.2	16.0	183.9	167.6	3.0	170.6	13.3	269.3
Intermediate estimates:													
2005	167.8	8.7	0.4	0.3	2.3	0.0	15.5	195.0	179.6	2.9	182.5	12.5	281.8
2006	178.1	9.5	0.4	0.4	2.4	0.0	15.8	206.6	191.6	3.0	194.5	12.0	293.8
2007	188.1	10.9	0.5	0.2	2.6	0.0	16.2	218.4	203.7	3.0	208.0[11]	10.5	304.3
2008	197.7	12.7	0.5	0.2	2.8	0.0	16.8	230.6	216.3	3.0	219.4	11.3	315.6
2009	207.7	14.1	0.5	0.2	2.9	0.0	17.3	242.7	230.2	3.1	233.3	9.4	325.0
2010	218.1	14.8	0.5	0.2	3.1	0.0	17.6	254.3	245.3	3.2	248.5	5.9	330.8
2011	229.0	17.1	0.5	0.3	3.3	0.0	17.8	268.0	261.5	3.2	264.8	3.2	334.0
2012	240.0	19.8	0.5	0.3	3.5	0.0	17.9	281.9	279.9	3.3	283.2	–1.3	332.8
2013	251.0	22.2	0.5	0.3	3.7	0.0	17.6	295.3	299.8	3.4	303.2	–7.9	324.8
2014	262.4	24.5	0.5	0.3	3.9	0.0	16.9	308.4	320.4	3.5	323.9	–15.5	309.3

Table III.C1.—Operations of the SMI Trust Fund (Cash Basis) during Calendar Years 1970-2014

[In billions]

	Income					Expenditures			Trust fund	
Calendar year	Premium income[1]	General revenue[2]	Transfers from States	Interest and other[3,4]	Total	Benefit payments[4,5]	Administrative expense	Total	Net change	Balance at end of year[6]
Historical data:										
1970	$1.1	$1.1	—	$0.0	$2.2	$2.0	$0.2	$2.2	–$0.0	$0.2
1975	1.9	2.6	—	0.1	4.7	4.3	0.5	4.7	–0.1	1.4
1980	3.0	7.5	—	0.4	10.9	10.6	0.6	11.2	–0.4	4.5
1985	5.6	18.3	—	1.2	25.1	22.9	0.9	23.9	1.2	10.9
1990	11.3	33.0	—	1.6	45.9	42.5	1.5	44.0	1.9	15.5
1995	19.7	39.0	—	1.6	60.3	65.0	1.6	66.6	–6.3	13.1
1996	18.8	65.0	—	1.8	85.6	68.6	1.8	70.4	15.2	28.3
1997	19.3	60.2	—	2.5	81.9	72.8	1.4	74.1	7.8	36.1
1998	20.9[7]	64.1[7]	—	2.7	87.7	76.1[8]	1.5	77.6	10.1	46.2
1999	19.0[7]	59.1[7]	—	2.8	80.9	80.7[8]	1.6	82.3	–1.4	44.8
2000	20.6	65.9	—	3.5	89.9	88.9[8]	1.8	90.7	–0.8	44.0
2001	22.8	72.8	—	3.1	98.6	99.7[8]	1.7	101.4	–2.8	41.3
2002	25.1	78.3	—	2.8	106.2	111.0[8]	2.2	113.2	–7.0	34.3
2003	27.4	86.4	—	2.0	115.8	123.8[8]	2.3	126.1	–10.3	24.0
2004	31.4	100.9	—	1.5	133.8	135.4	2.9	138.3	–4.5	19.4
Intermediate estimates:										
2005	37.2	123.2	—	1.3	161.8	155.5	4.4	159.8	1.9	21.4
2006	50.8	194.1	$9.0	2.0	256.0	239.5	3.7	243.1	12.9	34.2
2007	53.2	201.4	9.9	2.6	267.2	255.7	3.8	260.1[9]	7.1	41.4
2008	55.6	210.9	10.9	3.1	280.4	273.3	3.9	277.2	3.2	44.6
2009	64.2[7]	234.9[7]	11.9	3.3	314.4	292.0	4.1	296.1	18.3	62.8
2010	57.8[7]	224.6[7]	13.0	3.6	299.0	308.9	4.3	313.2	–14.2	48.7
2011	67.5	251.9	14.2	3.8	337.4	330.7	4.4	335.1	2.3	51.0
2012	73.6	275.2	15.5	4.0	368.3	360.9	4.6	365.5	2.8	53.7
2013	81.4	304.3	16.8	4.3	406.8	397.9	4.8	402.7	4.1	57.9
2014	89.7	335.7	18.3	4.6	448.3	438.3	5.0	443.2	5.1	62.9

[1]Premiums for Part D include only amounts withheld from the Social Security benefit checks or other Federal payments.

[2]Includes Part B general fund matching payments, Part D subsidy costs, and certain interest-adjustment items.

[3]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income.

[4]See footnote 2 of table III.B4.

[5]Includes costs of Peer Review Organizations from 1983 through 2001, and costs of Quality Improvement Organizations beginning in 2002. Values after 2005 include additional premiums collected from beneficiaries and transferred to managed care plans, where the monthly plan cost exceeds the benchmark amount, and Part D drug premiums collected from beneficiaries and transferred to Medicare Advantage plans and private drug plans.

[6]The financial status of SMI depends on both the assets and the liabilities of the trust fund (see table III.C12).

[7]Section 708 of the Social Security Act modifies the provisions for the delivery of Social Security benefit checks when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Delivery of benefit checks normally due January 3, 1999 occurred on December 31, 1998. Consequently, the Part B premiums withheld from the checks ($1.5 billion) and the associated general revenue contributions ($4.7 billion) were added to the SMI trust fund on December 31, 1998. These amounts are excluded from the premium income and general revenue income for 1999. January 3, 2010 will fall on a Sunday, and therefore, the delivery of the Social Security checks is expected to occur on December 31, 2009.

[8]Benefit payments less monies transferred from the HI trust fund for home health agency costs, as provided for by the Balanced Budget Act of 1997.

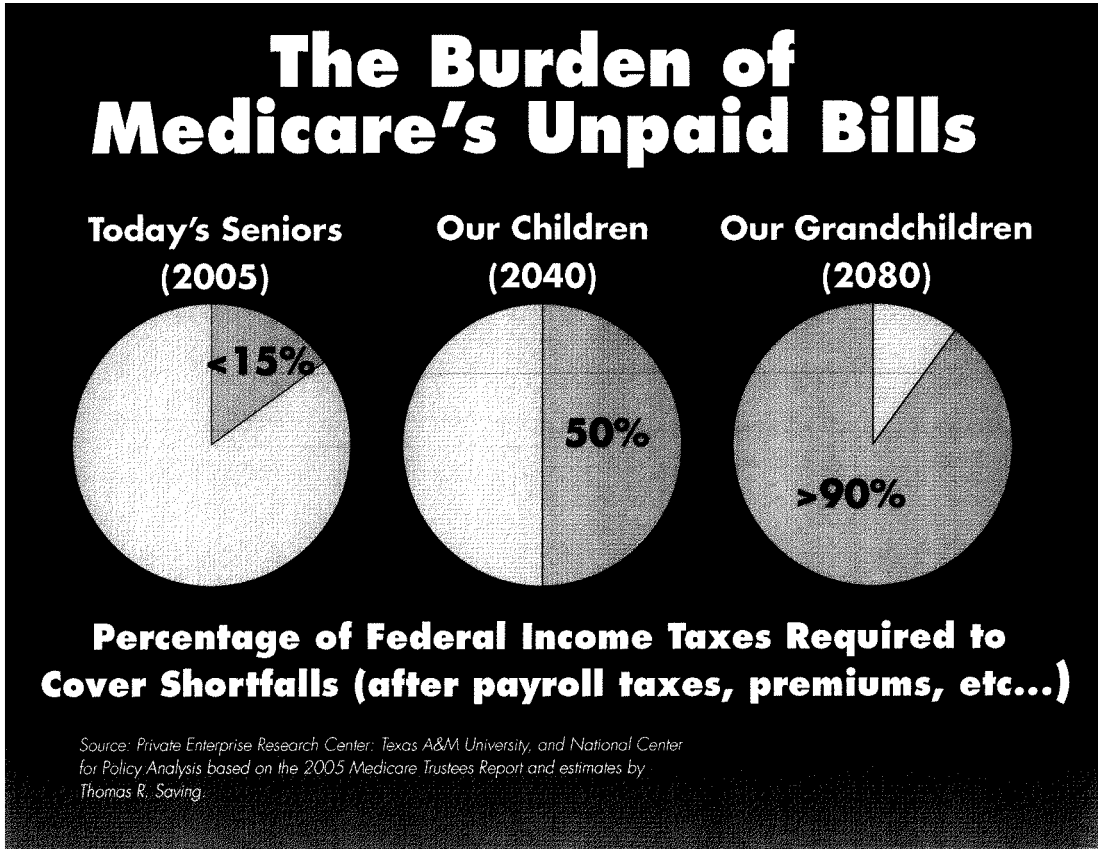
[9]Includes payment of estimated contingent liability payable to States (to reimburse them for payments they have made on behalf of beneficiaries) for probable unasserted claims that resulted from processing errors where incorrect Medicare eligibility determinations were made ($584 million).

Note: Totals do not necessarily equal the sums of rounded components.

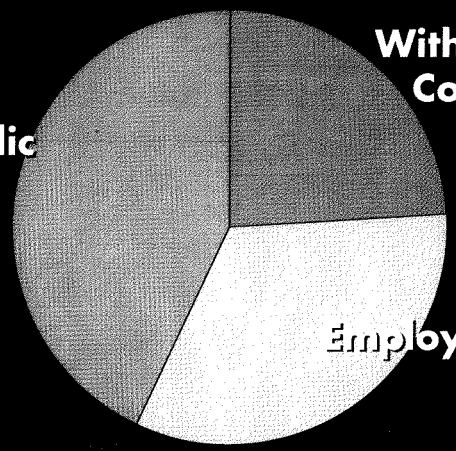
Costs and Projections for Medicare and Part D

$29.7 trillion	75-year unfunded liability for Medicare, per MMA *(2005 Trustees Report)*
$8.7 trillion	75-year unfunded liability added by Part D alone *(2005 Trustees Report)*
$855 billion	10-year COST of Part D *(CBO mid-session review, Aug. '05)*
$68.1 trillion	Infinite horizon unfunded liability of Medicare *(2005 Trustees Report)*
$18.2 trillion	Infinite horizon unfunded liability of Part D *(2005 Trustees Report)*
$4 trillion	Social Security shortfall (75-year unfunded liability) *(2005 Trustees Report)*
$11.1 trillion	Social Security shortfall (infinite horizon) *(2005 Trustees Report)*
$125.6 billion	Medicare funding shortfall for 2005, before Part D has even been implemented *(2005 Trustees Report)*
32%, $104.8 billion	Percent increase in non-defense, non-homeland security discretionary budget since 2001 *(OMB 2006 President's Budget)*
$2.5 trillion	FY2006 Budget Request *(2006 President's Budget)*
$17.2 billion	Net savings proposed in FY2006 budget request (.66% of total budget) *(OMB 2006 President's Budget)*
$200 billion	Likely Presidential request for Katrina reconstruction

9-22-2005


The Burden of Medicare's Unpaid Bills
Today's Seniors (2005)
<15%
Our Children (2040)
50%
Our Grandchildren (2080)
>90%
Percentage of Federal Income Taxes Required to Cover Shortfalls (after payroll taxes, premiums, etc...)
Source: Private Enterprise Research Center: Texas A&M University, and National Center for Policy Analysis based on the 2005 Medicare Trustees Report and estimates by Thomas R. Saving.

Pre-MMA: Where Beneficiaries Got Their Drug Coverage



Source: CMS analysis of the non-institutionalized Medicare population. 2002 projection.

TESTIMONY OF

LESLIE NORWALK
DEPUTY ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES

BEFORE THE

SENATE SUBCOMMITTEE ON
FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION
AND INTERNATIONAL SECURITY
OF THE
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS

HEARING ON

FINANCING THE NEW MEDICARE DRUG BENEFIT

September 22, 2005

Testimony of
Leslie Norwalk
Deputy Administrator
Centers for Medicare & Medicaid Services
Before the
Senate Subcommittee on Federal Financial Management,
Government Information and International Security
of the
Committee on Homeland Security and Governmental Affairs
Hearing on
Cost and Medicare Part D
September 22, 2005

Chairman Coburn, Senator Carper, distinguished members of the Subcommittee, thank you for inviting me here today to discuss the financing of Medicare's new prescription drug coverage. This important new coverage will significantly improve the lives of our beneficiaries and we are well on our way to a successful implementation this coming January. We have met our deadlines so far and will continue to do so.

At its inception, the Medicare program was designed to address the needs of patients with acute health problems. Hospital and physician services for existing diseases or disabilities were covered, but no provision was made for preventive service. In addition, because prescription drugs played a relatively minor role in health care, they were not included in the Medicare program. Claims for covered medical services and products were also processed through Centers for Medicare & Medicaid Services (CMS) contractors, but these entities did not provide coordination or oversight of care to ensure that beneficiaries receive evidence-based, clinically appropriate, integrated care. Medical science and practice have evolved over time, as we should expect them to, and until recently the Medicare benefit design had not kept pace as well as it might. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) helps to address these shortcomings and brings the Medicare program in line with modern medical practice.

In the past several years, Congress has added a number of preventive screening tests to the package of Medicare benefits. Under the MMA two new screening tests were added,

one for diabetes, and another for cardiovascular disease. The MMA also provided all newly qualifying beneficiaries with a "Welcome to Medicare" physical. During this initial visit with their physician, beneficiaries will have the chance to review their personal and family health history and will be given a wide array of screening services now covered by the program. This initial physical will help them identify, early on, any conditions they can address through dietary and lifestyle changes, medication, or otherwise, instead of waiting until something goes wrong to visit their physician. The "Welcome to Medicare Physical" provides an opportunity to identify potential problems before they develop into acute or severe chronic conditions.

The Medicare Advantage (MA) program provides beneficiaries with the choice to have all of their care coordinated through a single entity. The majority of individuals covered in the private market today receive their care through a preferred provider organization (PPO). The PPO screens providers and facilities, encourages them to provide clinically sound care, and may provide patients with coordination of their care so that the various physicians and facilities involved with them better communicate concerning the patient's needs. Furthermore, PPOs provide patients with the flexibility to go outside of established networks if they so choose. Most Medicare beneficiaries have not had access to this model of care though it prevails in the private market today. Instead, during a single episode of care their claims may be processed by several different entities, and they will have to deal with a range of caregivers that may or may not have avenues for coordinating care, and payment systems that do not always provide incentives to encourage the highest quality of care. This has changed with the implementation of the MA program.

The existing MA coordinated care plans and the new local and regional MA PPOs offer all of these services to people with Medicare. People with Medicare who receive their care through an MA plan have the added bonus of lower out of pocket costs than do those in traditional fee-for-service Medicare. For a typical person with Medicare who receives their care through an MA plan, the savings average $100 per month over what they would spend in regular fee-for service, and savings are higher for those in poor health. To the

extent that a MA plan's bid for providing Medicare benefits is below the established benchmark amount, which is generally based on prevailing fee-for-service costs in the area, it receives payments in addition to its bid to fund improved benefits, reduced cost-sharing or reduced plan premiums. This can mean savings for people with Medicare who enroll in an MA plan, or expanded services, such as coverage for eyeglasses, hearing aids and other items not currently covered under traditional Medicare.

Of all the improvements created under the MMA, the new Medicare prescription drug coverage stands out as perhaps the most important. Medications have become such a critical part of modern medical treatment that the lack of prescription drug coverage in any health plan would be considered a major limitation. The new Medicare prescription drug coverage will provide significant savings for the typical person with Medicare, who could see his or her total drug spending drop by about 50 percent. Those with extremely high costs will have excellent catastrophic coverage, and, most important, people with Medicare who have limited income and resources will have nearly their entire prescription drug costs covered. Congress put a great deal of careful thought into designing a benefit that would meet the most important needs of those with Medicare, while at the same time would remain fiscally sustainable for generations to come.

Currently, about three-quarters of people with Medicare have some form of drug coverage. A third of people with Medicare receive coverage under employer-sponsored retiree health plans. Unfortunately, employers have not been able to sustain the high costs of health care coverage for their retirees and over the past few years have been withdrawing that coverage, or increasing the share of enrollee costs. The Kaiser Family Foundation's annual survey of large companies' health benefits, for example, found that health insurance coverage was offered to sixty-six percent of retirees in 1988, but only thirty-three percent in 2005. It is unlikely that, given the high rate of health care cost increases, employers will be able to sustain even current rates of coverage. As a result, many people with Medicare who are now covered under their retiree plans could, absent the new Medicare prescription drug coverage, see their drug coverage erode or be eliminated in the coming years. The MMA provides an incentive for employers to help

maintain retiree coverage. This provision helps limit Medicare costs because amounts paid as incentives to employers, on a per person basis, are less than it would cost the Federal government to enroll these individuals in the new Medicare prescription drug coverage. An additional benefit of encouraging employers to maintain their retiree coverage is that their retirees will experience less disruption in their insurance situations.

For several years, people with Medicare have had the option of purchasing a private "Medigap" insurance policy that, in addition to covering deductibles and cost sharing for hospital and physician services, offered limited coverage for prescription drugs. As many as 10 percent of current individuals with Medicare have drug coverage under such a plan. If they are satisfied with such coverage, they can maintain it after the new Medicare prescription drug coverage begins in 2006. They may also decide to transition to one of the new drug plans. Since the new drug plans are heavily subsidized by Medicare, enrollees can receive improved coverage with the new Medicare prescription drug coverage at a lower premium cost than they would through a Medigap plan.

The nearly 11 percent of people with Medicare who receive their health coverage through their MA plan may continue to receive prescription drug coverage under that plan, if it is offered, or may select coverage under another MA or Medicare prescription drug plan.

The Federal government will also transition beneficiaries who are dually eligible for Medicaid and Medicare to prescription drug coverage under Medicare, relieving the states of a significant portion of this financial burden under Medicaid. (States are required to pay a declining portion of the drug costs that they would have incurred for such beneficiaries.) Those individuals constitute about 12 percent of people with Medicare.

Nearly 25 percent of people with Medicare have not had prescription drug coverage to this point, and have had to pay out of their own pocket for the full cost of their medications. After passage of the MMA, these beneficiaries were given the opportunity to obtain a Medicare approved prescription drug discount card at little or no cost. Several

million have done so, which resulted in substantial savings for them while waiting for implementation of Medicare's prescription drug coverage. CMS research showed that people with Medicare who obtained a Medicare approved prescription drug discount card could save 12 to 21 percent on brand name drugs compared with national average retail pharmacy prices and much more through the use of generics and mail order pharmacies. We also found that these individuals could save 10 to 75 percent over national average retail pharmacy prices for individual drugs often used to treat some common health conditions. Certain individuals with limited incomes were also eligible to receive $600 in 2004 and 2005, transitional assistance to help with their drug costs until the Medicare drug benefit becomes available.

Beginning in 2006, all people with Medicare will have the opportunity to take advantage of the new drug coverage, obtaining reduced costs for their medicines as well as coverage for catastrophic drug costs.

Mr. Chairman, you have expressed particular concern over the projected costs of the new Medicare prescription drug coverage. It is important to understand how these budget projections are created, and avoid apples to oranges comparisons between past and present projections.

The CMS estimates for the net cost to the Federal government for the Medicare prescription drug program have remained virtually unchanged since the program was enacted. CMS' actuaries originally projected that the benefit would have a net cost to the Federal government of about $147 billion over the period 2004-2008. Their current projections are now about $148 billion for the same period. The underlying economic assumptions used for these estimates have only been modified slightly to reflect updated data now available, such as modified assumptions about inflation. About 25 percent of the costs of the basic Medicare prescription drug coverage for enrollees who are not eligible for additional assistance will be financed by beneficiary premiums. The remaining approximately 75 percent will come from the Federal government's general fund. Those amounts are reflected in the costs estimates noted above. In addition, low-

income beneficiaries with limited resources are eligible to receive a federal subsidy to cover a large portion of their cost-sharing and premiums, and employers who provide drug coverage to their retirees are eligible for special subsidy payments from Medicare. The costs of these subsidies are paid from Federal general revenues. A portion of the cost of the Part D program is also met through the State payments that represent a percentage of their forgone costs for drugs on behalf of dual Medicare-Medicaid beneficiaries.

The Administration's initial estimate of the cost of the drug benefit included 2004 and 2005, years prior to implementation of the Medicare prescription drug program. During these years, the Federal government's expenditures were for the transitional assistance for low-income beneficiaries with Medicare approved prescription drug discount cards. The five-year projection in the current President's budget now includes five full years during which the Federal government will be incurring expenses for medications covered under the new Medicare drug program. As a result, the most current five-year cost estimate is $281 billion. The actuaries' updated estimates for individual years, however, are not significantly different from their original estimates.

It is also important to consider the fact that expenditures differ from costs. Expected Federal expenditures include amounts collected from beneficiaries as premiums that are then paid out to the various drug plans. While on a ledger these amounts appear as expenditures by the government, they are, in fact, not a cost to the Federal government because they are being borne by the beneficiaries. Statements about the benefit costing over $1 trillion include premiums collected and paid out by the Federal government as if they were actually costs incurred by the government, as opposed to a facilitated transfer of funds between beneficiaries and the drug plans.

We should also take into account the fact that although Medicare expenditures will rise due to the Medicare prescription drug coverage, Federal Medicaid expenditures will be reduced from what they otherwise would be. The Federal government pays a share of States' costs, and when people who are dually eligible for both Medicare and Medicaid

begin receiving their medications through a Medicare plan, as opposed to their state Medicaid plan, the Federal government will no longer be paying matching funds to the states to reflect expenditures on drugs covered under the new Medicare prescription drug program for these individuals. States may continue to pay (while receiving a Federal match) for drugs that are excluded under the Medicare prescription drug program.

Though budget projections and cost estimates have not yet had time to take this into account, I would make special mention of the fact that bids from drug plan sponsors have come in at a lower level than what was anticipated. Our original estimate of monthly premiums was $35, which was later revised upward somewhat to $37. However, we recently announced that the nationwide average monthly premium will be about $32 during 2006. This also means that the Federal expenditures might be lower in the first five years than initially projected. It is also worth noting that there will be plans available nationwide, with premiums as low as $20, and in some cases, even less. Furthermore, some good news for people with Medicare is that several plans will be offering a plan structure with deductibles lower than the standard $250, even as low as $0. The impact of these lower than expected premiums has yet to be taken into account in cost projections for the Medicare prescription drug program. And while costs in 2006 will be likely be lower than previously estimated, the impact in later years is uncertain at this time.

The competition among drug plan sponsors that likely contributed to these low premiums will not disappear after the first year. In fact, the language of the MMA was carefully crafted to increase competition over time. Premiums will be set each year, based on weighted bids submitted by entities seeking to sponsor Medicare drug plans. In the bidding sequence, all plans submit a bid for the cost of providing the drug benefit to a typical person with Medicare in the service area or areas on which they intend to serve. CMS reviews the bids, and all approved bids are compiled into a national average, weighted by each plan's enrollment share in the prior year. Premiums will be set at 25.5 percent of the national weighted average (with an adjustment to incorporate the impact of Medicare "reinsurance" payments for beneficiaries with very high drug costs), plus or

minus any difference between the plan's bid and the national average. Plans that submit bids falling under the national average will be able to offer lower premiums, and thus attract more beneficiaries. Over time, it is anticipated that plans offering the best prices and services will attract more beneficiaries, and as a result, the weight of their bids in subsequent annual processes will increase, thereby restraining the growth of the national average bid. The Medicare prescription drug program is a system designed to place continual downward pressure on prices and to create incentives for plans to provide efficient plan operations and good customer service as they compete with each other for market share.

A very positive aspect of this design is that the Federal government does not need to be involved with the business of establishing prices for drugs covered under the program. Our experience with establishing prices in Medicare Part B and Medicaid has proven to be very challenging, with constant discussion about whether prices have been accurately and adequately established. Congress has, on multiple occasions, directed CMS to modify drug pricing formulas and, indeed, one of the major aspects of the Medicaid reforms now under discussion is how to revise pricing for drugs covered under that program.

Drug plans participating in the Medicare prescription drug program will have a powerful economic incentive to establish the lowest prices they can, to bargain with manufacturers and pharmacies, to encourage people with Medicare to be cost-conscious in their use of prescription drugs (for example, by promoting use of generic drugs) and to compete strongly with other plans in the program. We saw a similar dynamic take place under the Medicare approved prescription drug discount card program, and, as mentioned above, it resulted in significant savings for beneficiaries who obtained those cards, savings greater, in fact, than we initially estimated. Because these savings were established through market mechanisms, the Federal government did not have to issue complex regulations, or collect proprietary data. Instead, real savings came, and they came quickly.

In addition to implementing changes mandated under the MMA, CMS is examining options to further align the economic incentives inherent in the various Medicare payment systems with the delivery of high quality, cost-effective care. CMS collects and disseminates quality-of-care data on nursing homes and home health agencies. These publicly available data allow beneficiaries and their families to make informed decisions about the providers from which they obtain care. These data may also motivate providers to improve their own performance if they fall below national norms. Recently, CMS began collecting and posting quality data on hospitals. This last action was taken after Congress supplied CMS with the authority to make a relatively minor adjustment of less than one-half of one percent in payments to hospitals that submitted required quality data. Initially a voluntary effort with relatively low participation, today, nearly every hospital in the country submits these data. Consistent with the President's FY 2006 Budget, CMS is exploring ways to develop a physician pay-for-performance system in a way that saves money or is at least cost-neutral. CMS believes very strongly that Medicare payments should recognize and reward high quality and efficient care, rather than simply paying for the number of services performed. We look forward to working with the Congress in that effort.

In addition to moving toward a pay-for-performance model in Medicare, CMS has been engaged in a number of disease management programs. In general, these efforts focus on those people with Medicare who have more costly health care needs due to chronic health problems that require substantial ongoing care, such as diabetes, heart and pulmonary diseases. Typically, these programs involve educating people about the positive results of consistently taking their medications, keeping track of indicators that can forecast impending acute problems (i.e., blood pressure), making life-style changes (diet and exercise), and seeing a primary care physician quickly should a need arise to revise their plan of care. The goal of these programs is to help beneficiaries achieve a stable, higher quality of life, and to reduce the number of acute episodes they experience that necessitate very costly emergency room or inpatient admissions. We anticipate the data being gathered from these efforts will help CMS as we work to design a program that

more adequately promotes quality and improves the lives of people with Medicare, while simultaneously showing where cost savings may be achieved.

In the end, that goal is what the Medicare program is all about, and we believe that the new Medicare prescription drug program will have a significant positive impact on the lives of the millions of American citizens who depend on us for their care. I thank the Subcommittee for inviting me here today and I look forward to any questions you may have.

Medicare and the Prescription Drug Benefit: Increased Pressure for Reform

Joseph R. Antos, Ph.D.

Wilson H. Taylor Scholar

in Health Care and Retirement Policy

The American Enterprise Institute

Testimony Before

U.S. Senate

Committee on Homeland Security and Governmental Affairs

Subcommittee on Federal Financial Management, Government Information, and International Security

September 22, 2005

Mr. Chairman and Members of the Committee: Thank you for inviting me to appear before you. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. I am also adjunct professor in the School of Public Health at the University of North Carolina at Chapel Hill. I have previously served as the assistant director for health and human resources at the Congressional Budget Office, and earlier held several research and management positions in the Health Care Financing Administration, the precursor to the Centers for Medicare and Medicaid Services (CMS). The views I present today are my own, and do not represent the position of the institutions with which I am associated.

Passage of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) in 2003 marked a major milestone for Medicare. For the first time, all beneficiaries will have access to outpatient prescription drug coverage under Medicare Part D. Special low-income subsidies will be available to needy beneficiaries, and millions of seniors and disabled people will save money when they buy their medicines under the new program.

All of this comes at a cost. The new program is the largest entitlement expansion since Medicare was established four decades ago. The huge sums that the federal government will spend through this program will largely be funded out of general tax revenues. That means the new drug benefit was enacted without being fully financed through specifically earmarked funds, and every dollar spent by beneficiaries will add 75 cents to the federal government's budget deficit. By adding the new benefit without full funding, Congress has increased the cost pressures that threaten Medicare's stability.

My testimony today will address three points related to the Medicare prescription drug benefit and the financing challenges facing the entire Medicare program:

- The drug benefit will be expensive, but we do not yet know what it will cost. Actual spending over the next decade could be substantially larger than assumed in the latest ten-year cost estimates. Moreover, the ten-year cost does not include the trillions of dollars of outlays the drug benefit will incur past 2015.

- The drug benefit has added substantially to Medicare's unfunded liabilities, which will require renewed efforts to reform the program. We cannot simply tax our way out of the problem. Higher taxes reduce future job opportunities and economic growth, which further complicate the problem of providing future generations of older Americans with health care benefits.

- Medicare's traditional approaches to cost containment—federal price setting and limiting access to care—are unlikely to be effective in the long run. Such policies would distort treatment decisions and reduce incentives for the development of innovative new drugs.

Additional reforms will be needed if we are to maintain a financially viable Medicare program. The MMA included elements intended to promote competition, consumer choice, and financial incentives for greater efficiency. It also established the precedent that beneficiaries

most in need should receive greater subsidies in Medicare. Those principles should be the basis for future reforms of the program.

Cost of the Drug Benefit

Public discussion of the Medicare prescription drug benefit has been confused by the plethora of cost estimates that have been released by the Congressional Budget Office (CBO) and the administration over the past few years. Each new estimate seems to be larger than the last, causing some to believe that the program's costs have risen precipitously even before the full benefit was established. That is not correct, if only because we do not yet have any relevant cost experience for the program on which to base a new assessment. Nonetheless, it is likely that even the latest estimate understates the federal cost of the program.

CBO initially scored MMA as increasing federal outlays by $395 billion between 2004 and 2013.[1] That score, released in the fall of 2003, assured that the legislation would not exceed the $400 billion that had been allocated for Medicare in the Senate budget resolution. Subsequently, the administration revealed its analysis, which estimated costs of $534 billion over the same period.[2] The meaning of that difference in estimates may have been lost in the resulting storm of controversy. The disagreement showed that even the experts were uncertain about how the drug benefit would work.

Debate over the numbers flared up again this year with the release of new estimates in the administration's 2006 budget. Payments to health plans for the drug benefit totaled $1.2 trillion between 2006 and 2015. However, that figure excluded savings offsets built into the drug benefit: beneficiary premiums, payments from states (the "clawback"), and lower federal spending in Medicaid. Net of those savings, the cost was $724 billion.

Although the new numbers were higher than the original estimates, the administration had not changed its analysis of the program's cost. The main reason for the seemingly large increase was the change in the time period over which the cost was estimated. The original estimates covered an earlier ten-year period, which included only eight years of a full drug benefit. The other two years (2004 and 2005) included the cost of the prescription drug discount card program, which was far less expensive. The latest estimates measure the cost of the full benefit for the entire 10 years. In other words, the higher new estimates did not imply that program costs had taken an upward turn.

CBO also issued a new, seemingly higher, cost estimate this year. In February, CBO released an estimate showing $795 billion in higher Medicare outlays between 2006 and 2015 as a result of the drug benefit. However, that estimate is not comparable to the administration's new estimate because it omits other savings that would accrue to the federal government outside

[1] CBO estimated that the drug benefit would cost $409 billion, but other provisions of MMA lowered the cost of the full bill to $305 billion.
[2] The administration estimated that the drug benefit would cost $511 billion, with other provisions of MMA raising the cost of the full bill to $534 billion.

the Medicare program. A comparable number would be somewhat lower than $795 billion. CBO, like the administration, had not fundamentally changed its view of the cost of the program.

The CBO estimate has since been revised twice, in March and again in August, to capture changes in economic and technical budget assumptions. The drug benefit was projected to increase Medicare outlays by nearly $850 billion using the March scoring baseline. The latest revised estimate using the midsession baseline came in at $855 billion over the next ten years. As was the case with the February estimate, those projections do not include some savings that would accrue to programs other than Medicare.

The administration and CBO seem to agree that the drug benefit will increase federal outlays by more than $700 billion and perhaps as much as $850 billion over the next ten years. However, a ten-year cost estimate only scratches the surface. Medicare provides a permanent entitlement to payment for covered services, and under current law that commitment will not expire.

Over the longer term, Part D's cost is much higher. The Medicare trustees estimate that Part D spending net of beneficiary premiums and state payments will total about $8.7 trillion over the next 75 years, measured in present value terms. That is the amount of money that must be transferred from general tax revenue to pay the cost of Part D in full. Measured over the infinite horizon, the necessary amount of general revenue transfers rises to $18.2 trillion.

The cost of the prescription drug benefit could be even larger if the actuaries have misjudged the response of patients, drug plans, employers, and others to the new program. Beneficiaries might respond to the new subsidies by using more prescription medicines than assumed in the estimates. The use of prescription drugs also might increase more than expected if there are unexpected breakthroughs in pharmaceutical research and development, bringing more innovative products to the market. Drug plans might find that seniors' drug use is less amenable to their cost management practices (such as step therapy, which requires the patient to start with the least expensive drug in a class). More employers might drop their retiree drug coverage than assumed in the cost estimates. There are many other possible changes in behavior that could lead to program costs higher than have been estimated.

Perhaps the greatest vulnerability to higher-than-expected Part D spending stems from the activities of policymakers. The way in which the Centers for Medicare and Medicaid Services (CMS) implements and regulates the new benefit could have a significant impact on the prospects for cost containment. For example, CMS has taken steps to ensure that drug formularies are not overly restrictive. While that may mean greater access to prescription drugs for beneficiaries, such actions could limit the drug plans' ability to shift market demand toward lower-cost drugs.

Congress might also be tempted to increase the generosity of the Medicare drug benefit in future years. For example, there may be pressure to fill the "donut hole," a gap in coverage requiring that the patient pay the full cost for drug spending between $2,250 and $5,100, or the

low-income subsidy might be extended to more beneficiaries. Such policies could increase the cost of the benefit substantially above the levels suggested by current estimates.

Can We Make Good on Medicare's Promises?

By any metric, the Medicare prescription drug benefit represents an enormous additional commitment of the nation's resources to the cost of seniors' health care. The benefit also has added significantly to the financial pressures facing the country in the decades ahead as the baby boomers age into retirement. Over the next 75 years, Part D will require new general revenue transfers of $8.7 trillion. That is on top of the $21.0 trillion shortfall projected by the Medicare trustees for Part A and Part B.

Medicare is facing a fiscal crisis of historic proportions. Broadly speaking, there are three possible responses to such a crisis: ignore it, raise program revenue, or reduce program spending. We consider each in turn.

Ignore the crisis. If we took no action—in effect, ignoring the crisis—we would be relying on the economy to grow sufficiently to accommodate the rise in health spending without unduly sacrificing other important spending priorities. Even when economic growth is accounted for, spending on the three major entitlement programs (Medicare, Medicaid, and Social Security) could increase from the current 8.4 percent of GDP to 17.4 percent by 2030, according to the Congressional Budget Office.[3] By 2050, spending for those programs could reach 27.6 percent of GDP. According to CBO, this situation is unsustainable unless the health spending slows significantly below historical rates. Even then, tax revenues would probably need to be higher than in the past.

Raise program revenue. We could raise program revenue by increasing the income tax or the payroll tax, or by increasing premiums paid by beneficiaries. We will focus on the first two forms of revenue raising because they each have a broad tax base and it is conceivable that their tax rates could be raised sufficiently to cover the Medicare financial shortfall. Premium increases could supplement the revenue raised through higher broad-based taxes but premiums alone are unlikely to be sufficient given the vast sums that would be necessary.

According to the Medicare trustees, the payroll tax would have to be immediately and permanently doubled—rising from 2.9 percent to 5.99 percent of taxable earnings—to fully fund Medicare Part A for the next 75 years. However, Part A is only part of Medicare's underfunding problem.

Unless we are prepared to cut back drastically federal spending for education, housing, transportation, defense, and other program areas, taxes also would have to be increased to

[3] The long-range projections use CBO's "high spending path" estimates for health programs, reported in CBO, *The Long-Term Budget Outlook*, December 2003. Those projections assume that the historical growth in health spending continues into the future. Since they were developed before the Medicare drug benefit was enacted, the projections may understate future health spending.

finance Medicare Part B and Part D if we took no actions to cut spending. In research forthcoming from the Heritage Foundation's Center for Data Analysis, Tracy Foertsch and I estimate that the Medicare payroll tax would rise to about 13.4 percent of taxable earnings if we funded the entire Medicare shortfall (including Part B and Part D) through that tax vehicle.

Such a large increase in payroll taxes would be intolerable. The tax hike would slow growth in the economy, significantly reducing GDP, employment, saving, and investment. Policymakers are unlikely to propose such a drastic long-term tax increase, but they might consider more modest revenue increases to fund Medicare over a shorter time period. However, even a short-term revenue-raising policy would have deleterious economic effects.

We simulated the impact of raising payroll and income taxes to finance Medicare fully through 2015, using Global Insight's short-term U.S. Macroeconomic Model. That would be a temporary solution. After 2015, Medicare would again spend more than it received in earmarked revenue. According to our estimates, GDP would fall by $90 billion annually and nearly 880,000 jobs would be lost each year, on average. By dampening economic activity, large tax increases undercut our ability to finance future consumption.

Our estimates might be optimistic, however, since they assume that Congress would use the additional revenue solely to pay for Medicare spending or to buy down the national debt. If policymakers followed their historical behavior, they would use some of the new tax revenue to finance increased federal spending outside the Medicare program—necessitating a higher tax increase. In that case, the economic consequences would be more severe than we have estimated.

Reduce program spending. Most analysts agree that growth in Medicare spending should be reduced, but there is little agreement on how that should be done. Some argue that the program's regulatory approach, which relies on direct government price setting and limiting access to health services, has been effective at controlling cost. Others argue that Medicare spending would be slowed more effectively if beneficiaries could choose from among competing private plans.

Price controls and other regulatory restrictions could push prices below the level that would prevail in a competitive market, but only for a limited time. Below-market prices ultimately cause shortages as patients demand more health care goods and services than providers and manufacturers are willing to produce. If the shortage—or the perception of shortage—became severe, policymakers would take actions to ease restrictions on price.

That reaction has been demonstrated with Medicare's "sustainable growth rate" formula, which mandates cuts in physician fees when past spending exceeds a target. Faced with the prospect of 4 to 5 percent annual fee reductions, physicians have demanded relief, asserting that Medicare patients were beginning to experience problems accessing services. Congress has responded several times, although only with temporary price increases since the budgetary cost of a permanent change in the formula is large. This remains an issue of great concern to

policymakers, who continue to seek ways of providing rate relief to physicians.[4]

Over the long term, price controls would be no more effective in limiting spending growth than a competitive system.[5] However, controls would distort the pricing signals that promote efficiency in competitive markets. In such markets, prices rise when demand for a product increases, encouraging producers to supply more of the product. A price kept artificially low provides no incentive for producers to increase supply and satisfy consumer demand.

An approach to cost containment embraced by all sides acknowledges that some portion of Medicare spending is wasteful. Medicare pays for both necessary and unnecessary care, of high quality and low, delivered in efficient and inefficient manners. If we could eliminate the unnecessary, poor quality, inefficient care, Medicare spending would be reduced significantly. We do not have the means to accomplish this, although the expansion of health information technology, evidence-based medicine, pay for performance, and other initiatives could begin to chip away at some of the wasteful spending in Medicare. Despite a great deal of recent interest, such methods may develop slowly and are unlikely to yield enough savings by themselves to resolve Medicare's long-term financing crisis.

Cost containment in Part D. MMA prohibits CMS from negotiating pharmaceutical prices with manufacturers. Such negotiations, which are essentially government price controls by another name, would have a serious unintended consequence. Government price setting creates additional uncertainty about the potential returns to innovation, discouraging research and development that could lead to new drugs for cancer, dementia, or other diseases of the elderly.

Instead, Part D plans will tailor their benefits and premiums to attract enrollment, and they will be partially at risk for costs that exceed their bid amounts. That provides an incentive for the plans to manage their costs and negotiate the best price they can for the products.

Significant savings are possible under this structure. The Government Accountability Accounting Office (GAO) found that pharmacy benefits managers (PBMs) in the Federal Employees Health Benefits Program obtained substantial discounts, ranging from 18 percent below the cash price for brand-name drugs purchased at retail pharmacies to 53 percent for

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[4] Rep. Bill Thomas and Rep. Nancy L. Johnson, Letter to Mark McClellan on Medicare physician payment, July 12, 2005.

[5] Previous empirical studies of the effectiveness of Medicare cost controls compared to private sector approaches have been interpreted as supporting both sides of the argument. One approach compares the trends in health spending under Medicare and private insurance (see Cristina Boccuti and Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades," *Health Affairs* (March/April 2003), pp. 230-237; Joseph Antos, "The Role of Market Competition in Strengthening Medicare," testimony before the Senate Select Committee on Aging, May 6, 2003; and Michael J. O'Grady, "Health Insurance Spending Growth: How Does Medicare Compare?," Joint Economic Committee, June 10, 2003). Such estimates are sensitive to adjustments necessary to make "apples to apples" comparisons, and the results vary depending on the time period over which spending is observed. Those studies look at the *past* performance of Medicare and the private sector in controlling cost growth. That may not be adequate to assess how well a *specific* reform of Medicare would control cost growth *in the future*.

generic drugs purchased through mail-order pharmacies.[6] In addition, PBMs received manufacturer rebates of 3 to 9 percent, and saved 1 to 9 percent through interventions such as prior authorization and drug utilization review. These impressive results are the product of a strongly competitive private market for prescription drugs.

Whether Part D plans can achieve similar savings remains to be seen. Much depends on how CMS implements the program and the restrictions that are placed on the use of private sector cost management tools in Medicare. Congress and CMS will discourage overly vigorous cost containment methods that could adversely affect patients.

Policymakers will be tempted to impose government pricing on prescription drugs in Part D, particularly if program spending rises even faster than expected. However, government price setting is guided by social and political concerns, not market realities. If there are short-term budget savings, they would be offset by the cost imposed on patients from policy-induced shortages of pharmaceuticals. Although there might be a great demand for new drugs to treat particular diseases, pricing distortions would discourage firms from making the sizeable and risky investments necessary to invent those products. That misallocation of resources ultimately leads to a less efficient pharmaceutical sector.

It is incorrect to assume that if the government takes direct action on a problem, it will deliver the desired result—in this case, price controls leading to lower drug spending. Much of drug spending is driven by increased use of pharmaceuticals and the shift to newer drugs, which the drug benefit presumably is intended to promote. Spending growth is not primarily the result of price increases. As we have seen with past attempts to control spending for other health services, price control policies have only a limited effect on Medicare spending trends.

Conclusion

Although the Medicare drug benefit will help millions of seniors and disabled people, the new benefit has placed an unprecedented financial burden on the larger program. Unless significant changes are made in Medicare, rapid spending growth as the baby boomers start to reach age 65 in a few years will drain money from the federal budget. We have all been reminded that natural catastrophes can strike us, and recovery can cost hundreds of billions of dollars. By tightening our spending in other areas, we have the fiscal capacity to meet that challenge today. Will we be able to say that a decade from now?

Fortunately, important elements of MMA can provide a basis for the next, more thorough reforms that are needed. More private health plans will be competing in Medicare than ever before, and they will for the first time be paid according to their own assessment of the costs of doing business in their local communities—supplanting the formula-based pricing system that dictated reimbursements for such plans since the mid-1980s. Medicare Advantage plans should be permitted to compete fairly with the traditional Medicare program, and consumers should decide which type of health plan they want. MMA borrowed some ideas from the highly

[6] Government Accountability Office, *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies,* Report GAO-03-196, January 2003.

successful Federal Employees Health Benefits Program, but there are more lessons to be learned.

Congress must face the hard truth. We have made promises in Medicare that cannot be kept, and we have compounded those promises with the Medicare Modernization Act. We cannot expect even a robustly growing economy to solve this problem for us, and we cannot tax our way out of the fiscal crisis without doing damage to the economy. Prudence demands a reform that focuses on the incentives that drive Medicare spending.

Meeting Medicare's Future Needs

Testimony before the Subcommittee on Federal Financial Management, Government Information, and International Security U.S. Senate Committee on Homeland Security and Governmental Affairs

"Cost and Payment of Medicare Part D"

Marilyn Moon
Vice President & Director, Health Program
American Institutes for Research

Thursday, September 22, 2005

Note: The opinions expressed in this testimony reflect those of the author and not of AIR or its Board of Trustees

Mr. Chairman: I am pleased to be here today to discuss issues surrounding the new Medicare prescription drug benefit and cost issues facing Medicare in general.

My testimony argues that Medicare is not a failed program nor unsustainable as some of its critics contend. For 40 years, it has provided nearly universal coverage to a vulnerable population group, changed with the times, and done a better job of constraining costs than has the private sector. This government health care program remains popular with its constituents. In fact, it fares better than private insurance in polls of satisfaction with health insurance. And although financing challenges exist, they are not insurmountable. Maintaining its success and the features that people value about the program should be paramount. From the perspective of Medicare beneficiaries, the goal of changes in Medicare should be to seek genuine efficiencies in the delivery of medical care, to assure access to care for this population, particularly those with limited resources, and to find an equitable way to finance the program.

While concerns about the costs of Medicare are important, it is also the case that Medicare cannot function well if it is inappropriately restricted. The new prescription drug benefit—although limited in it comprehensiveness--is an important addition essential to assuring access to good health care. Delaying its implementation would be detrimental to Medicare beneficiaries. Finding the right balance of comprehensive benefits, access to care, and sources of financing are important decisions for assuring a stable future for Medicare. My testimony today makes several points about Medicare's costs and affordability:

- Historically, Medicare has done as well or better in holding down the costs of care as the private insurance system;

- Improvements in the efficiency and appropriateness of care can help reduce costs but will not be enough to avoid a greater need for financing for Medicare over time;
- Shifting more costs of the program onto beneficiaries is a means of financing and needs to be weighed against other financing options such as higher taxes;
- Medicare—even with drug benefits—is affordable over time; the more relevant issue is whether taxpayers are willing to pay more.

GROWTH IN MEDICARE COSTS

Medicare, like the rest of healthcare spending, has grown at a rapid clip when measured as a share of Gross Domestic Product (GDP). The addition of a drug benefit in 2006 means a substantial upward shift in program spending as compared to GDP. And with the first members of the Baby Boom generation nearing age 65, Medicare promises to grow even faster beginning in 2011 (see Figure 1). But as can also be seen in the figure, the growth closely tracks the increase in the share of Americans receiving Medicare. Medicare has already doubled the number of persons it covers and the numbers will double again by 2030. This doubling of the population in the future will substantially expand Medicare beneficiaries as a share of the total population.

The factors driving Medicare costs upward are not unique to the public sector. They are found throughout our nation's healthcare system, with the rising costs hitting all payers: individuals, businesses, and governments. Medicare influences the overall healthcare system, and vice versa. Although Medicare has been a leader in curbing the costs of care, both in terms of

increasing prices and use of services, costs continue to rise.

As compared to private insurance, Medicare has mostly held the line on growth in healthcare costs in the 1980s and 1990s. For example, between 1985 and 1992 Medicare had lower rates of growth--often considerably lower--than did private insurance. The mid 1990s did experience a short-lived slowdown in private sector spending growth relative to Medicare, the costs are again growing at nearly the same pace. Thus, a historical look at the data suggests that Medicare is not out of sync with the rest of the health care system. Indeed, the patterns in spending growth are very similar, and often below that of private insurance. This is particularly important given factors that could be expected to drive up the costs of care for this population relative to others. For example, Medicare's population is aging overall, adding modest pressures for higher spending over time (Moon 1999). Further, as new technology becomes safer and more effective, it is likely to expand faster among more frail populations like aging Medicare beneficiaries. The important lesson from comparing Medicare to other payers is not so much which sector is doing better at holding the line on costs at one point in time, but rather that healthcare costs tend to change in tandem no matter what the source of payment.

CHANGES TO POSITION MEDICARE FOR THE FUTURE

Efforts to achieve slower program growth have generated ad hoc efforts during many of the annual federal budget cycles since the early 1980s. Over time, these efforts substantially slowed Medicare's rate of growth, culminating in 1997 with substantial cutbacks as part of the Balanced Budget Act. In fact, the 1997 legislation (and some later efforts at reducing fraud and abuse) resulted in substantially lower projections for Medicare spending in the future. In 1998 and through 2000, the projections for spending on Medicare as a share of GDP declined (Figure

2). In fact, in 2005, even after the inclusion of a drug benefit, projections for spending are lower than in 1997. Progress can thus be made over time in holding down Medicare's costs.

Proposals to find additional ways to reduce the costs of providing healthcare to disabled and elderly Americans that eliminate unnecessary care or achieve greater efficiencies can reduce the overall bill for the program. Efforts to make progress on such changes should continue and will be important to Medicare's future. However, we should not be overly optimistic that such savings can overcome the need for increased financing over time.

One popular "magic bullet" suggested has been to shift beneficiaries away from the traditional Medicare program into private health insurance options as a way of achieving cost-saving efficiencies. Many policy makers have put their faith in the market and competition with little actual evidence to back this up. On balance, Medicare's per capita spending growth has actually been below that of private insurance since the early 1970s. Medicare has low administrative costs and gets very good discounts from doctors, hospitals and other providers of care. Thus, to save costs as compared to Medicare, private insurers would have to find improved ways to limit the use of services. This was the hope of managed care in the mid-1990s in the employer health insurance market, but few companies did it well. Push back from consumers and care providers to the arbitrary controls many insurers imposed reduced the hope that managed care would be an easy solution. Finding more reasonable ways to control the growth of costs poses a difficult challenge for both the public and private sectors.

Further, studies have indicated that people with health problems and the very old are not likely to shop for the cheapest health plans—one of the goals of competition. Disrupting health care treatments and finding new providers of care is not only distasteful to many consumers, but also can add to the overall costs of care. Savings from competition and reliance on private plans

will not go very far, however. Such efforts alone cannot assure that the numbers of individuals becoming eligible for the program can be provided.

Many of the remaining proposals to reduce Medicare spending focus on shifting costs onto beneficiaries and away from government spending is an answer for those opposed to taxes but not necessarily for reducing costs of health care to society as a whole. The argument has been to shift more of the responsibility for care to patients. Make them pay high deductibles and copays and they will become responsible consumers. Or, create a voucher program and shift the risks of higher costs over time to consumers. The problem is that this form of consumer "empowerment" can quickly become consumer "impoverishment" especially if consumers are ill-equipped to make decisions about what care is necessary and which providers are the most "efficient."

And, while senior citizens and persons with disabilities are better off then in the early days of Medicare, most are not driving golf carts at clubs in Florida. Rather, their incomes at best could be considered modest, and except for the wealthy, few have substantial assets upon which to draw. Over half of elderly households have per capita incomes below $25,000 per year. Baby boomers' incomes will be a little higher, but incomes will be slow to riser time. Further, beneficiaries already devote a substantial share of their incomes to healthcare costs (Figure 3). By 2004, they were spending more than before the passage of Medicare. High healthcare spending affects out-of-pocket costs as well as uncovered services. Medicare currently covers only 55 percent of the acute health care costs of its beneficiaries. This share will improve under the new prescription drug benefit, but only modestly.

Another way to shift costs away from government that has been suggested would be to raise premiums on those who do have more resources. But relying on rich seniors to help pay for

Medicare over time just doesn't get you very far because there are too few of them. The only way to make this a "solution" is to treat the definition of high income as $30,000 or $35,000 per year. At best, this would be only a modest part of any solution.

A third approach, mirroring one of Social Security's options, would be to raise the age of eligibility for Medicare. But for healthcare, there are substantial barriers. Pushing people out of Medicare would often mean that they would have to seek insurance in the private individual market, which currently functions well only for those without substantial health problems. A 66 year old with multiple health problems would likely find private insurance either very expensive or not available at any price. And reform in every state of the private individual market is not likely to happen any time soon.

Options for "saving money" under Medicare that simply shift costs onto beneficiaries implicitly answer the question of who should pay as "beneficiaries, not taxpayers." Yet the choices are seldom expressed that directly. Rather, in response to questions about the sustainability of Medicare, the usual answers tend to be that beneficiaries must bear a greater share of the costs, or that age of eligibility must change. But this sidesteps the question of who *should* pay by implicitly indicating that while "we" as a society cannot afford the taxes to pay for healthcare for an aging population, that somehow the elderly and disabled themselves can afford to do so.

What then are viable solutions? It is likely that, as in the past, Medicare will need to be re-evaluated periodically to seek savings where feasible and consistent with the rest of the healthcare system. Improving the delivery of health care so that as a society we get the biggest return for our dollars should be on everyone's agenda. Many studies have shown that Americans spend more than necessary on health care. But, efforts to identify unnecessary care and reduce it

are difficult; patients do not like to be controlled and careful attention to all the needs of a patient can sometimes result in higher costs. Investment in better information on what works is both needed and a logical role for society as a whole. Patients need to trust that denial of some services is justified by evidence and not just cost containment. The new prescription drug benefit would be a good place to start such an effort. This can save over the long run, but again is not likely to rise to the status of a "magic bullet." One way or another, society will have to find ways to pay for health care or accept the costs of unmet needs and the resulting lower quality of life for the Medicare population. Saving dollars for the federal government is not the end of the story. Changes that simply shift costs, such as premium increases or raising the eligibility age, are more appropriately considered financing options and should be contrasted with tax increases in the debate over Medicare's future.

MEASURING MEDICARE'S FINANCIAL HEALTH

Medicare is currently financed in a variety of ways. Part A relies mainly on payroll taxes with a modest contribution from part of income taxes on Social Security benefits. Part B is financed by enrollee premiums set at 25 percent of the costs of Part B benefits for elderly beneficiaries, and by general revenue contributions sufficient to cover the remaining costs. Part D will use essentially the same financing structure as Part B.

Medicare's financial health can be viewed from several perspectives. The appropriate question over time is whether, *as a society*, we can afford to support Medicare. That is, are health care costs for the elderly and disabled beneficiaries likely to be so high that some people will need to go without care? And how should that be balanced against healthcare priorities across all age groups and as compared to other spending? The severe limitations imposed by looking only

at current or future federal revenue burdens implies that limitations on government spending can "solve" the problem. But since people will still need to get care somewhere, if the burdens are simply shifted onto beneficiaries and their families, *society* will be no better off. In that case, the issue essentially becomes one of *who* should pay. It is important to look carefully at the claims made on Medicare's financial status, and recognize that both spending and financing issues are at stake.

Existing Measures

The first and most commonly cited measure is the date of exhaustion of the Part A Trust Fund. This is one of several basic measures that have traditionally been reported in the Medicare Board of Trustees annual reports on Medicare's financial outlook. The Part A Trust Fund was designed to assure that the designated payroll tax contribution would be used specifically for Part A—Hospital Insurance— spending. As dedicated revenues, payroll and other revenue sources that exceed the amount necessary to cover Part A benefits go into the trust fund and collect interest. When the forecasts indicate a declining balance in the trust fund, this is an early warning of the need for an adjustment either in revenue contributions or spending on the program.

Projections of the Medicare Part A trust fund indicate that it will maintain a positive balance through 2020. Considered in historical context, the date of projected insolvency has moved up compared to 2001, but still remains further into the future than it has been over most of Medicare's history. The trust fund balance in 2004 was $269 billion or 158 percent of annual Part A expenditures. It is expected to grow to $334 billion in 2011 and then decline over time as a share of Part A spending. Certainly this signals a need for change.

However, this measure ignores Part B issues and so does not take into account the full size of the Medicare program. But since Part B's trust fund is kept in balance by automatic infusions of general revenue and funding for the two parts are kept separate by law, a "solvency" measure is difficult to devise for Medicare as a whole.

A second indicator often cited is the ratio of workers contributing to Medicare at any point in time compared to the number of beneficiaries. This measure shows that, given the aging of society, the number of younger persons relative to older ones will decline in the future. This declining ratio of workers to retirees indicates that each worker will have to bear a larger share of the cost of providing payroll tax-financed Medicare benefits. Indeed, the numbers are quite dramatic. Between 2000 and 2035 (several years beyond when most Baby Boomers will have become eligible for Medicare), the ratio of workers to beneficiaries will fall from 3.90 to 2.21. This change represents a 43 percent decline in the ratio through 2035. Indeed, this is one of the statistics commonly cited by those who claim the program is "unsustainable." This measure does signal the need for more revenues per worker—a legitimate issue for debate. However, it fails to assess the level of burden relative to ability to pay from each future worker, ignoring any improvement in the economic circumstances of workers over time due to per capita economic growth.

A third measure, which has long been included in the annual reports but is now getting more attention, is the sum of Part A and B spending as a share of GDP. In 2000, Medicare's total share was 2.3 percent and is projected to rise to 5.0 percent in 2030 for Parts A and B and to 6.8 percent when prescription drugs are included (again see Figure 1). This represents nearly a tripling of the GDP share. Such an increase reflects the fact that health care costs per capita are expected to continue rising, and the number of people covered will double over that time period.

This measure puts potential costs into the context of U.S. aggregate production and offers more information than the worker-to-retiree ratio. Also, since both Parts A and B are included, it provides a broader look into the future than when the focus is only on Part A solvency. It is not a very intuitive measure, however, as there is no natural benchmark for what an appropriate share would be, particularly as the share of the population covered by Medicare rises over time. In addition, it may not be as helpful in the debate on Medicare's future because it does not consider how well off we will be as a society as the level of GDP grows. Some goods and services, like health care, may appropriately grow as a share of GDP in response to higher living standards.

A More Comprehensive Measure of Affordability

Another way to look at affordability is to focus not just on the *number* of workers that contribute to payroll and income taxes nor on aggregate GDP, but instead on how the Medicare per capita burden will affect workers over time. While the share of the pie (GDP) going to Medicare is likely to rise, if the pie (on a per capita basis) is also much larger, then an increasing share is less of a burden. If the future leads to increased national well-being, additional resource sharing would be affordable. So another way to examine affordability is to focus on whether taxpayers of the future will be better off even *after* they pay higher amounts for Medicare. Such a measure examines whether, as a society, we can *afford* such care for this population.

The measure I prefer to use begins with computing per worker GDP over time, resulting in a measure of the nation's output of goods and services divided across the working population. It is an indicator of how well off we will be as a society over time. This provides the base for assessing Medicare's burden on workers, who pay for the bulk of support for the program. Per worker GDP—even after adjusting for inflation—rises substantially, from $74,914 per worker in

2005 to over $124,421 in 2035 (in 2004 dollars). This is an increase of 66.1 percent in per worker GDP, a substantial increase in financial well-being.

What about Medicare's costs over this period? The burdens from Medicare spending on each worker are projected to rise at a faster *rate* than per capita GDP because both numbers of beneficiaries and their inflation-adjusted spending will rise over time. But because per worker GDP is a much larger dollar amount than Medicare burdens, the reduction in well-being that this entails for workers is modest. Each worker will bear an increasing share of Medicare over time because of the change in the ratio of workers to retirees. Further, per capita Medicare costs are expected to rise faster than GDP by 2035, also increasing the real dollar burden on workers. But not all of Medicare's costs are borne by workers. Costs are adjusted downward by projected beneficiary contributions both from premiums and from their expected contributions to general revenues.

The resulting real per worker burden estimates range from $1,906 in 2005 to $5,567 in 2035 (in 2004 dollars) based on Medicare spending before adding in the costs of prescription drugs. The burden in 2035 rises to $7,303 per worker in 2035 when the drug benefit is included. From 2005 to 2035, the increase in per worker resources (after subtracting Medicare excluding drugs) would be 60.0 percent as compared to the 66.1 percent increase in per worker GDP. When the cost of the new drug burden is added, the growth in per worker GDP falls to 57.2 percent. That is, workers would still be substantially better off than today, even after paying the full projected costs of Medicare with the prescription drug benefit. And if further cost savings are achieved as is likely, the burdens will be lower and net GDP per worker growth will be higher.

This more comprehensive measure of net per worker output also suggests that, as a society, we will be able to afford Medicare without an inordinate burden on workers or taxpayers once even modest estimates of productivity growth over time are taken into account. The pie will indeed have gotten larger. However, tax rates would have to rise to pay for such benefits. The challenge will be for society to decide whether it is *willing* to pay some or all of these costs.

DECIDING HOW TO SPREAD THE BURDENS OF MEDICARE

The combined effects of rising healthcare costs and an aging population (resulting in a growing share of the total population) will increase Medicare spending as a share of GDP. By 2030, the burden on taxpayers (who are not also beneficiaries) will be a little less than 6 percent of GDP. Also, over this period, the share of income spent by seniors and persons with disabilities will rise from the same healthcare cost increases that help drive up Medicare's spending. If, as discussed earlier, beneficiaries (and their families) pay the same share of total acute care costs through time as at present (and after adjusting for the new drug benefit), they will effectively pay an amount equivalent to about 2.5 percent of GDP in 2030 for their portion of Medicare services (and an even higher amount if non-covered services were to be included. The appropriate question for Medicare is how to balance the 2030 GDP burden of acute care costs of 8.5 percent between taxpayers and beneficiaries over time. Thus, under current law, the share will be split 70/30 between taxpayers and beneficiaries respectively. Should that balance change over time?

Although there has been little public discussion about increasing revenues to help fund the future of Medicare, it is essentially the elephant in the room that no one wants to recognize.

The impetus for change has been almost exclusively in the other direction at the federal level in recent years—i.e. lowering taxes. If Medicare is to remain without massive cuts in eligibility or benefits, additional revenues will be needed. Since it is unlikely that any one change will be sufficient to address the financing issues facing Medicare, a combination of options will likely be needed. A "fair" distribution of the burdens of financing Medicare also needs to be based on a number of considerations. Nonetheless, Medicare is affordable from the perspective of the likely economic situation of the economy as a whole.

Future workers will have higher standards of living so increased contributions are possible. But the will to support tax increases needs to be there. Further, the decision should be an explicit one, weighing the ability to pay of both Medicare beneficiaries and taxpayers (some of whom are also Medicare beneficiaries). At this point in time, it is difficult to contrast the abilities of future younger taxpayers to pay more as compared to future Medicare beneficiaries. In general, however, it would be safe to assume that living standards are less likely to rise as fast for those who are out of the labor force than for those who remain in the labor force. In addition, it is likely that seniors and persons with disabilities will face rising costs of health care over time relative to their incomes. Certainly, they are unlikely to be able to absorb enough new per capita costs to avoid any more general tax increases and still sustain a viable Medicare program. That may suggest the current balance of 70/30 between younger taxpayers and beneficiaries of Medicare's costs might need to change.

For Medicare to remain a viable program, it will be essential to increase revenues from payroll or other broad-based taxes. Otherwise, it will not be possible to cover the growing share of the eligible population. It is just as harmful to make unnecessary cuts in Medicare as it is to ignore the need to make financing adjustments. A large number of uncertainties over health

service delivery and the private insurance market need to be resolved before it is clear what major steps need to be taken. If some of the reforms described above begin to slow Medicare growth to more reasonable levels, less restructuring or other changes might be needed over time. Thus, a reasonable strategy would be to establish a schedule of financing adjustments to be made periodically on the basis of 10 year projected costs and changes in relative economic well-being between the old and the young. If as a society we decide to support the Medicare program, we have the capability of doing so.

An Evaluation of Medicare's Prescription Drug Policy

Testimony Submitted To

Committee on Homeland Security and Government Affairs

**Subcommittee on Federal Financial Management,
Government Information, and
International Security**

United States Senate

by

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Chairman Coburn, Senator Carper, members of the Committee, thank you for the opportunity to testify on the Medicare Prescription Drug Program. I feel very honored by it.[1]

I especially appreciate this opportunity because no policy issue appears more vital than how to preserve the efficient operation of health care markets to pay for our growing health care needs. It is well known that designing policies to improve health-care market efficiency is difficult. But it is not yet widely appreciated how huge Medicare's future financial shortfall is. The Medicare Prescription Drug Improvement And Modernization Act of 2003 (MMA) substantially increases that shortfall and is likely to worsen the operation of markets for prescription drugs and drug insurance. As such it deserves urgent reconsideration—a view that is shared by many health care experts and policymakers including, I suspect, by members of this Committee.

I. Introduction:

MMA offers prescription drug coverage to *all* retirees. The new law will benefit seniors on the whole but will exert several negative economic effects:

Five issues stand out:

- Government intervention is usually justified when private markets fail. With 75 percent of retirees already having prescription drug coverage and 90 percent having access to prescription drugs prior to MMA, this market did not exhibit the symptoms of "market failure." Indeed, passage of MMA is likely to *cause market failure* by displacing the private market's provision of drug insurance.

- MMA will improve access to prescription drugs for poorer retirees – both those who are and those who are not currently covered under Medicaid. Well-to-do retirees will also benefit in general but some may experience higher out-of-pocket costs if they lose their private drug coverage and are forced to enroll into Medicare Part D. This law, therefore, appears designed to first displace the private market followed by sustained pressure on Congress to liberalize the MMA's benefit formula over time.

- MMA will influence prescription drug prices in the private market as the share of government-subsidized purchasers expands. Theoretical reasoning and empirical studies suggest that private drug prices would increase with additional government-subsidized patients entering the market. Most of the burden of this increase will fall on workers by making employer-provided health insurance or private plans more

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expensive. That will reduce younger workers' likelihood of employment, cause lower wage growth, increase conversion from full- to part-time jobs, and reduce work effort.

- MMA makes a large addition to the already considerable financial shortfall in the rest of Medicare. Unresolved, this shortfall will grow larger and impose higher fiscal burdens on future generations, further eroding their productivity and work incentives.

- MMA will change workers' and younger generations' perceptions about the need to save for health-care expenses during retirement. Studies show that expansion in government entitlement obligations leads to higher consumption and reduces national saving and investment—delivering a further negative impact on future worker productivity and output.

MMA was hastily passed without a proper evaluation of its short- and long-term cost and it lacks appropriate measures to control spending escalations. That means future Congresses may be induced to regulate the actions of pharmacies, drug manufacturers, employers, and plan providers with regard to drug pricing and spending per person on prescription drugs. Such regulations would be counterproductive because they would restrict prescription drug supply, generate illegal prescription drug sales, and reduce the quality of prescription drug coverage for everyone – and not just for retirees.

If MMA cannot be repealed, a financially and economically sensible course would be to scale it back to a sustainable level by providing coverage only to those seniors who are under financial pressure on account of their prescription drug expenses. That effort needs to be combined with restoring the rest of Medicare to financial sustainability.

II. Pre-MMA Prescription Drug Coverage of Retirees

Prior to MMA's enactment, Medicare Parts A and B provided no limits on out-of-pocket costs and did not insure retirees against outpatient prescription drug expenses.

The vast majority of retirees (75 percent) had prescription drug coverage under private plans: Employer supplemental health coverage (33 percent), Medicaid and state drug programs (17 percent), Medicare+Choice Plans (15 percent), Medigap policies with prescription drug coverage (2 percent) or other sources (8 percent).[2] New retirees were guaranteed access to 10 alternative Medigap plans, three of which covered prescription drugs.

[2] See "Cost Sharing Policies Problematic For Beneficiaries and Program," Testimony by William J. Scanlon before the Subcommittee on Health, Committee on Ways and Means, United States House of Representatives, May 9, 2001.

Some retirees, however, faced financial pressure on account of their prescription drug costs: Estimates as of 2000 suggest that average out of pocket costs for retirees in poor health took up about 44 percent of their incomes.[3] Low-income single women not covered under Medicaid spent about 52 percent of their incomes on health expenses, on average.

Enrollment into Medigap plans including prescription drug coverage has been quite low. Such plans impose spending caps and so do not cover catastrophic expenses. Their high premiums, deductibles and cost-sharing requirements make them expensive and their availability varies widely by geographic area. Premium inflation among plans with prescription drug coverages has been very rapid. The plans also provided first-dollar coverage that discouraged prudent use of services and prescription drugs.

These features made Medigap policies inferior to employer supplemental coverage, which generally had low co-insurance requirements, no separate spending caps for prescription drugs, and drug prices after negotiated discounts. Employer plans also do not provide first-dollar coverage, thus promoting prudent use of health services including prescription drugs.

III. MMA, the Drug Market, and Retiree Prescription Drug Coverage

Drug treatments are becoming standard practice treating chronic conditions. Greater intensity of use of existing drugs and the development of new and more effective, but also more expensive, drugs have increased the *entire population's* dependence on drugs therapies. Higher drug development costs and higher demand for drug treatments have caused drug prices to grow rapidly.

1. Is There "Market Failure" in the Prescription Drug Marketplace?

Data (cited earlier) show that a significant share of retirees already had access to prescription drugs and drug insurance. About 90 percent of seniors reported taking at least 1 prescription drug. Thus, MMA represents an increase in government intervention in prescription drug and drug insurance markets where there was no prior market failure.

Whether the provision of a good or service is financed by the government or through private markets makes a large difference to whether the economy's scarce resources are allocated efficiently. Efficient allocation of resources implies their use in meeting the most important needs first—as signaled by peoples' willingness to pay.

It is well known that government intervention replaces resource allocation through competitive forces by allocation through fiat. Because the government does not maximize

[3] The remainder was accounted for by Medicare premiums, deductibles, co-payments and cost sharing. See "Medicare Cost Sharing Policies Problematic for Beneficiaries," Testimony by William J. Scanlon before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, May 9, 2001. [GAO-01-713T]. See also [GAO-01-941]

profits, federal price setting and resource allocation decisions are not based on market signals of efficient resource use. The usual result is a loss in economic efficiency. That will happen to the prescription drug and drug insurance markets because of MMA.

That does not necessarily mean that market outcomes are fully acceptable. If there is considerable inequality of wealth or of needs among individuals, market operation will provide goods and services to the rich, whereas the poor will be unable to make their demands effective. Because such outcomes may be socially unacceptable, government intervention could be justified – but only at the margin – to assist those in need of subsidies because of economic misfortunes.

A study based on 2003 data indicates that only 25 percent of retirees reported forgoing medications due to high costs.[4] The most vulnerable categories of retirees on account of prescription drug expenses are those without any drug insurance (50 percent spending $100 or more on prescription drugs), those in low-income groups (34 percent spending more than $100 per month) and those with three or more chronic conditions (42 percent spending more than $100 per month).

It is usually difficult to demarcate the appropriate extent of government intervention on account of wealth inequality. MMA clearly oversteps all reasonable limits, however, because it provides a broad drug subsidy to *all* retirees regardless of their economic status, previous access to prescription drug coverage, and prescription drug needs.

MMAs generosity will significantly worsen the economy's ability to allocate resources efficiently – directly by reducing the size of the private market, increasing drug prices, imposing larger than necessary tax burdens on current and future productive citizens, and indirectly by reducing their ability and willingness to save and invest for the future.

2. Who Will Benefit From MMA?

Dual eligible beneficiaries – those eligible for both Medicaid and Medicare coverage—will now receive drug coverage through Medicare. The lowest income beneficiaries among them will receive premium and cost-sharing subsidies as well—and would have to pay out-of-pocket only for nominal drug co-payments. Low-income cost-sharing support would be phased out for families with higher income and assets.

Dual beneficiaries will not lose the value of their coverage. Indeed, their drug coverage is likely to become more generous under Medicare Part D compared to Medicaid—especially as state budget problems increase the likelihood of stricter future cost containment measures under Medicaid. Several states already regulate the number of prescriptions filled per period, the number of allowable refills, size of dosages, and drug dispensing frequencies etc. These limitations will be disallowed when dual-eligible

[4] See "Prescription Drug Coverage And Seniors: Findings from a 2003 National Survey," by Dana Gelb Safran and co-authors, Health Affairs, web-exclusive, April, 2005.

beneficiaries are shifted to Medicare Part D—making their prescription drug coverage more valuable.

Many states facing budget pressures are likely to increase their cost-sharing requirements in the future making Medicaid benefits less valuable. Hence, taxpayer costs of covering dual eligibles' drug insurance may be higher under Medicare Part D because Medicaid savings "clawed back" by the federal government are likely to be smaller than the actual costs saved.

In addition, MMA will benefit seniors with poor health and considerable dependence on costly prescription drugs—including those who purchase Medigap plans offering prescription drug coverage. As mentioned earlier, such plans' premiums, deductibles, and cost-sharing requirements can amount to thousands of dollars. In contrast, Medicare Part D's co-insurance rates are only 5% beyond expenditures exceeding $5,100. For example, under Medigap plan J, retirees must spend $6,250 out of pocket to attain the maximum benefit of $3,000 (implying total annual health care spending of $9,250). In contrast, Medicare Part D's cost-sharing formula would pick-up $5,059 of spending up to $9,250 leaving the beneficiary better off by $2,058 per year.[5]

Medicare Part D will also benefit those retirees who choose to purchase Medigap plans without prescription drug coverage because they face restrictive choices among available plans. Such purchasers constitute the vast majority of Medigap clients.

3. Some Retirees May Pay More in the Long-term

Generally, employer provided retiree health coverage is broad, includes comprehensive drug coverage, requires low co-pay and co-insurance rates, and does not impose separate caps on drug expenses. In contrast, Medicare Part D premium, deductible, and co-insurance costs will be substantial for those with drug expenses up to $5,100 per year. Hence, during the short-term many retirees may choose to remain under employer-provided prescription drug insurance.

Over the long-term, however, MMA is likely to induce employers and other private providers to restrict or eliminate retiree drug coverage. Those covered under such plans would then be forced to sign up for Medicare Part D and could face *larger* out-of-pocket costs—unless they qualify for additional low-income subsidies. This is likely to increase political pressure to shrink or eliminate the "donut-hole" in the benefit formula. That, in turn, could prompt yet more seniors to drop their private coverage and enroll into Medicare Part D, increasing the program's already high overall costs.

Thus, although retirees as a whole would gain considerably, on net, from the implementation of MMA, some retirees may become worse off over the long-term if employers cut costs by dropping retiree drug coverage. That means some of MMA's benefit won't stay with retirees but flow through to employers. Employers' overall gains

[5] *Ibid*, [GAO-01-713T].

could be limited, however, as prescription drug usage expands and drug prices increase. Those effects would increase the cost of providing health care insurance to workers.

IV. MMA's Impact On The Private Drug Market

The government already subsidizes prescription drug use by Medicaid patients. The federal subsidy is provided through the states' Medicaid programs. States possess set drug reimbursement rates within but must adhere to federally specified upper-payment limits. Drug reimbursement rates to providers, however, must be set to ensure drug provision consistent with the provision of other complementary medical services within each state. Rates must also ensure that comparable service levels available to those eligible for Medicaid in all states.

Drug prices and federal and state drug spending under Medicaid has escalated recently because of increased drug use and availability of new, effective, but more expensive drugs for replacing traditional medical treatments. Because prices of established drugs are not allowed to rise by more that the Consumer Price Index, manufacturers have set high initial prices for drugs that are technically "new" but work very much like older versions already on the market.

The entry of sizable additional government-subsidized patients (retirees) in the drug market means either that drug manufacturers must ramp up drug production or substitute sales to Medicare in place of sales to private purchasers including drug exports.

Some studies have estimated that post-MMA increases in drug demand would be small. But they assume that those who already purchase prescription drugs will not change their use of prescription drugs. That assumption defies past experience.

Those who lack coverage today would increase their drug usage as they obtain insurance against out-of-pocket costs. So also would those with very high dependence on prescription drugs because MMA reduces their cost-sharing expenses. In addition, MMA is likely to reduce state restrictions on drug usage for dual-eligibles—whose drug costs would now be met through Medicare Part D. And doctors will hesitate less in prescribing drugs now that their retiree patients have acquired access to a new "third party" payer.

As mentioned earlier, drug usage intensity is likely to increase as MMA expands retiree budgets for prescription drugs. Consequently, the demand for drugs is likely to increase considerably and will likely cause higher-than-projected program outlays.

If manufacturers can increase drug production without significant additional costs it may be feasible to accommodate the additional demand without significant price increases. However, in a competitive marketplace where manufacturers must accept the highest price offers first, pharmacies and, in turn, the federal government may have to increase offer prices to manufacturers to obtain additional drug supplies for their new Medicare patients. In that case, prices charged in the private market must also increase and the size of the private drug market must become smaller. Thus, theoretically, an

increase in the drug market share of government patients would increase drug prices and shrink the private drug market.

This theoretical expectation is supported by empirical evidence on the relationship between the government's share in particular drug markets and the private market prices of those drugs. A study covering 200 drugs during 1997 and 2001 found that government participation in the drug market through Medicaid significantly increased drug prices faced by non-government payers.[6] An increase in the government's market share by 10 percent was found to be associated with a 10 percent increase in the drug's price. This finding remains true despite to the addition of several controlling factors such as drug therapeutic classes, the existence of generics, the number of close substitutes, and the time since the drug's first introduction.

Considering Medicaid's market share in the top 200 drugs, the study suggests that private-market drug prices would have been lower by 13.3 percent, on average, in the absence of Medicaid. Greater intensity of drug use by retirees would, therefore, imply yet higher prescription drug prices. Thus, with federal drug insurance guaranteed to all retirees, the higher drug prices will negatively impact *workers* through employer-sponsored or privately provided health plans. As a consequence, employers may seek to cut back on wages, reduce workers' health-care coverage, increase health-insurance premiums, or convert full-time jobs to part-time positions that do not provide health benefits.

Another recent study documents that higher health insurance costs are taking a heavy toll on workers.[7] Each 10 percent hike in health insurance costs reduces the likelihood of being employed by 1.6 percent, and cuts hours worked by 1 percent. Workers whose health insurance is maintained are forced to accept smaller wage gains: A 10 percent increase in premiums is offset by a 2.3 percent decrease in wages.

The prior study also demonstrates that the government's drug rebate program operated for Medicaid—that limits established drugs' price increases to no more than the Consumer Price Index—leads to larger manufacturer incentives to introduce new drugs with slight performance enhancements but with initial prices set a much higher levels to compensate for the federal drug rebate program.

V. MMA's Financial Implications for Workers and Future Generations

CMS estimates that Medicare Part D's unfunded obligation (future outlays less enrollee premiums and cost-sharing) is zero. However, CMS assumes that Congress will

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[6] See "The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing," by Mark Duggan and Fiona Scott Morton, National Bureau of Economic Research, Working Paper No. 10930.

[7] See "Labor Market Effects of Rising Health Insurance Premiums," by Katherine Baicker and Amitabh Chandra, National Bureau of Economic Research, Working Paper No. 11160, August, 2005.

continue to authorize general revenue transfers to Medicare Part D as and when needed to bridge the gap between outlays and enrollee premiums. In present discounted value, total future general-revenue infusions required are estimated at $18.2 trillion. That is, Medicare Part D promises to provide net benefits to current and future generations of retirees to the tune of $18.2 trillion in excess of the premiums they will pay for enrollment into Medicare Part D.

According to CMS, Medicare's Parts A and B combined are estimated to require total financial infusions of almost $50 trillion in present value to meet benefit costs under current laws. MMA's enactment has, therefore, increased Medicare's fiscal burden on current and future taxpayers to $68.1 trillion. The additional charge on federal general revenues from the new drug program is significantly higher than Social Security's future financial shortfall—estimated by Social Security's Trustees to be $11.2 trillion.

An $18.2 trillion figure is better understood as a share of the present value of GDP from which it must be financed. According to CMS's projections, that share equals 1.9 percent. That is, MMA commits 1.9 percent of all future GDP to funding seniors' drug coverage.

Because, the entire GDP is not (and will never be) subject to taxes, it is more instructive to compare MMA's general revenue charge to the present value of the future income tax base from which all federal general receipts are drawn. Unfortunately, there is no official estimate of the present value of the income tax base. However, if future taxable (personal and corporate) income averages about 55 percent of GDP – its current ratio -- Medicare Part D's $18.2 trillion charge on general revenues would equal 3.5 percent of the present value of the income tax base.[8]

Because Medicare Part D is not financed out of a dedicated revenue sources, it is impossible to know when the implied fiscal burden -- either higher taxes or federal spending cuts -- would be imposed. It is also impossible to know how this fiscal burden will be distributed across different income groups and across living and future generations.

The calculation of MMA's fiscal burden above involves a critical assumption: That GDP and the tax base will remain unchanged despite the imposition of higher taxes or spending cuts. However, higher taxes will adversely impact work incentives and spending cuts may degrade critical economic infrastructure, both of which would adversely affect productivity. Thus, financing the $18.2 trillion charge on general revenues is likely to require an income tax-rate increase exceeding 3.5 percentage points because the "feedback" effect of financing MMA benefits through higher taxes on national output would reduce future national output.

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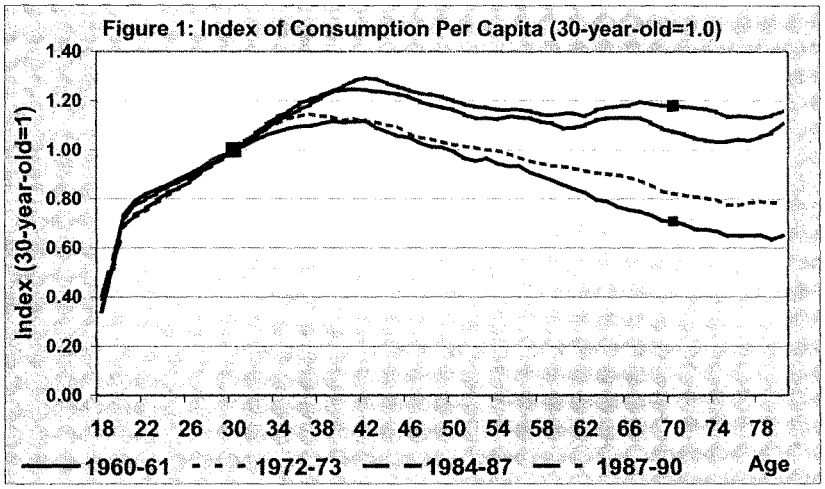
[8] The assumption that the share of taxable income in GDP will remain constant at 55 percent is quite optimistic. Labor income – a large component of taxable income – is expected to decline as a share of GDP as the baby-boomers leave the work force and enter retirement during the next two decades.

VI. The Impact of MMA on National Saving

The difference between what current generations earn by way of income each year and their annual consumption determines how many resources are saved and invested. The more current generations consume, the less is available for investment. The $18.2 trillion estimate of the present value of Part D benefit encompasses the entire future without a time limit. That is, it includes benefits that will accrue to future generations.

Unborn generations, obviously, do not consume out of current income. The impact of Medicare Part D's net benefit on *current* consumption depends on the share of it accruing to those alive today. The Medicare program's Trustees' have estimated that federal general revenue infusions into Medicare Part D will equal $8.7 trillion through the year 2079. Of this, $6.7 trillion will be on account of those alive today. That is, today's retirees and workers (those aged 15 and older) can, under MMA, expect to receive from the federal government $6.7 trillion dollars on net by way of prescription drug coverage.

As the drug law is implemented and as today's generations' expectations regarding their drug benefits become firmer, they will perceive an improvement in their total wealth position. Their natural response to higher perceived wealth would be to increase their consumption. As a consequence, national saving would decline.



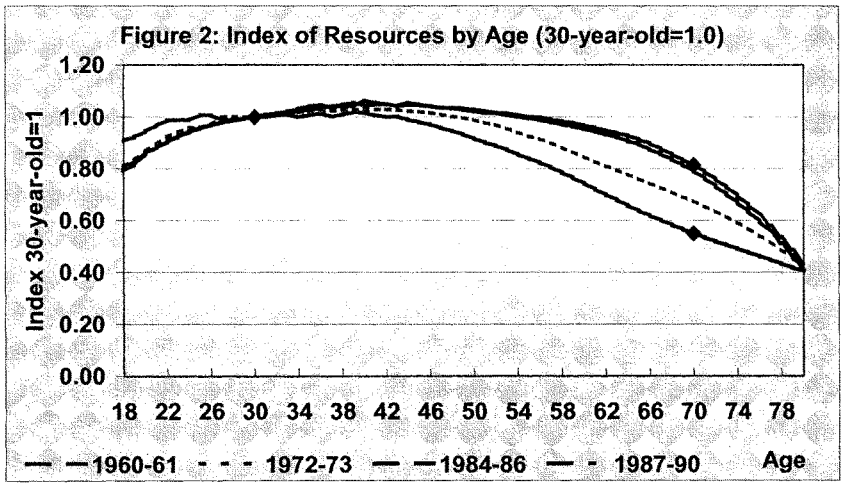
Evidence from survey data confirms that retirees increase their consumption in response to receipt of additional entitlement benefits.[9] Figure 1 shows consumption

[9] See "Understanding the Postwar Decline in U.S. Saving: A Cohort Analysis," by Jagadeesh Gokhale, Laurence J. Kotlikoff, and John Sabelhaus, Brookings Papers on Economic Activity, Winter 1996, pp. 315-407.

indices by age derived from the Consumer Expenditure Surveys for four periods: 1960-61, 1972-73, 1984-87 and 1987-90. In each period, the consumption per capita of all age groups is shown relative to the consumption of a contemporaneous 30-year-old person—whose consumption index is set equal to 1 in each of the four periods.

The figure shows that consumption per capita of 70-year-olds in 1960-61 fell short of 30-year-olds' consumption per capita in the same period by 29 percent. However, by 1987-90, 70-year-olds consumed 18 percent more per capita than 30-year-olds in the same period. More recent data also show the same pattern of increasing consumption levels by retirees relative to the consumption of their younger contemporaries.

One of the most important elements driving the change in relative consumption patterns by age appears to be the change in the pattern of resource ownership by age. The expansion of federal benefits by way of growing Social Security and Medicare outlays have transferred resources from workers to retirees during the past four decades. That process is continuing today with liberalized Social Security benefits and the enactment of new entitlement benefits -- such as Medicare Part D.



Those transfers have increased retirees' command over resources relative to those available to younger generations. Figure 2 shows total resource indices by age for the same four periods, where total resources include current net worth per capita and present values per capita of lifetime earnings, pensions, and government transfers from all programs.[10]

[10] *Ibid.*

Figure 2 shows that retirees' had more resources at their disposal compared to their younger counterparts' resources in 1987-90 than did retirees in 1961-62. The passage of MMA will continue the trend of increasing retiree resources relative to those of workers and younger generations. As a result, consumption by retirees is likely to increase and national saving will continue to decline.

How large would be the impact of MMA's cross-generation resource redistribution on saving? A Congressional Budget Office study reviewed academic literature on this question and concluded that for every $1 increase in federal unfunded entitlement obligations, current national saving declines by between 0 and 50 cents.[11]

That range indicates the considerable uncertainty surrounding such estimates. However, it suggests that the best estimate of the MMA's impact on national saving is negative. Taking the mid-point of the range of estimates, national saving may be expected to cumulatively decline by $1.7 trillion by the time today's workers achieve retirement age. That is, by 2079, the national capital stock would erode by $1.7 trillion and future Americans' income and living standards would decline correspondingly.

VII. Conclusion

MMA subsidizes retirees' prescription drug expenses but will probably lead to considerable economic inefficiency. It will improve prescription drug coverage for low-income seniors who were previously covered under Medicaid. It is also likely to benefit low-income seniors without Medicaid coverage and those with high drug expenses. It will also provide a substantial subsidy for those seniors previously covered against drug expenses under a Medigap policy. However, out-of-pocket costs of those seniors previously covered under an employer-provided prescription drug plan are likely to increase as employers increase their premiums to soak up the subsidy or reduce, possibly drop, their coverage completely leaving retirees to foot MMA's premiums and cost-sharing expenses.

MMA will increase the share of government-subsidized patients in the market for prescription drugs. That is likely to shrink the share of privately purchased drugs via higher drug prices. The adverse impact will mostly be on workers as the cost of employer provided health insurance plans increases. That will trigger lower employment, slower wage growth, reduced hours worked, and conversion of more full-time jobs to part-time jobs.

MMA's long-term costs represent a massive addition to the already steep fiscal burdens implicit in current Medicare Part A and Part B policies. This massive cost must eventually be met via tax increases or cuts in other federal spending such as defense, infrastructure, education, social welfare programs, R&D and so on. Meeting future health-care needs as projected under current policies through tax increases alone appears infeasible as higher tax burdens erode work incentives, lower employment, reduce

[11] See "Social Security and Private Saving: A Review of the Literature" Congressional Budget Office, July 1998.

national output and the tax base—requiring yet higher tax rates to draw the necessary revenues.

Past experience indicates that redistributing sizable amounts of resources from workers and future generations toward retirees will erode national saving and investment, and increase our dependence on foreign savings. Implementing MMA will induce a similar intergenerational redistribution of resources, causing higher consumption by retirees and reducing national saving. This is likely to further reduce worker productivity and exacerbate the output-reducing effects of higher taxes.

Overall, MMA is a bad and shortsighted economic policy. This program needs to be re-evaluated and recalibrated from its current focus on covering all retirees regardless of their health-care costs and ability to pay for prescription drugs. It should be refocused on those retirees who most need financial support against prescription drug expenses.

RESPONSES TO QUESTIONS FROM MS. NORWALK

From a Hearing Before the
Senate Subcommittee on Federal Financial Management,
Government Information and International Security
of the
Committee on Homeland Security and Governmental Affairs
"Cost and Medicare Part D"
September 22, 2005
Senator Coburn

Question 1:

Does CMS have the ability to negotiate drug prices? Please explain. If so, is there a way to use market indicators to avoid the adverse consequences of price controls?

Answer:

No. Section 1860D-11(i) of the Social Security Act, as amended by the MMA specifically prohibits the Secretary from interfering in drug price negotiations between plan sponsors and manufacturers and pharmacies.

Under the Medicare approved prescription drug discount card, plan sponsors engaged in direct, unfettered discount negotiations which resulted in prices that were lower than we had anticipated. We believe that prescription drug plan sponsors offering coverage through the Medicare prescription drug program will be able to negotiate similar discounts.

Question 2:

Reduction in medical costs for seniors was a major selling point of the drug benefit during the debate leading up to enactment. Why is CMS no longer assuming such a reduction in their cost projections?

Answer:

We continue to believe that the Medicare prescription drug benefit will cover around half of the costs for a typical beneficiary. For those with limited incomes and resources, the benefit will cover a much larger portion of their expenses. We have been very encouraged to see that the national average monthly premium will be around thirteen percent lower than we had anticipated, saving money for people with Medicare who enroll in the benefit and the Federal government. These lower than expected costs are not reflected in our FY 2006 mid-session review estimates for the cost of the program, but we anticipate doing so in our next budgetary projections.

In terms of the availability of drugs decreasing the amount of overall expenditures for Medicare beneficiaries' health costs, we do not have sufficient data to evaluate the

aggregate impact of the new benefit. Certainly modern medical practice utilizes medications to a far greater extent than in 1965 when the Medicare program began and the medications that will be covered under this program can make significant differences in the quality and length of life for our beneficiaries. We believe that Congress took a historic and laudable step when it decided to provide this new benefit.

Question 3:

Rising health care costs is one reason employers are dropping coverage. When Part D gives employers the excuse to pay nothing for drugs, why would they agree to continue paying for them, even if they are paying a discounted rate of 70% of their cost?

Answer:

The majority of people with health coverage in the United States obtain that through their employer and a significant, though dwindling number, continue to be covered through their employer plans when they enter retirement. Employers compete with each other on the basis of wages and benefits. The subsidy available to employers offering drug coverage to their retirees can be used in a variety of ways. Employers can continue to offer coverage that is equivalent to Medicare's (or better) and accept the subsidy for doing so. This helps ease some of the burden they have been carrying and, we believe, help address the steep rate of decline in health coverage being made available to retirees. Employers can restructure their retiree drug coverage so that it wraps around the Medicare program, covering all or some of the premium, deductible and cost-sharing expenses. This combined effort could well result in even better coverage for those retirees than the currently have. Finally, employers can sponsor their own Medicare prescription drug plan for their retirees.

All of these options are designed to motivate the employer to continue making some sort of contribution toward covering their retirees. The reality is that fewer and fewer employers are offering health coverage to their retirees and this trend is likely to continue. The employer subsidy was designed to encourage employers to continue offering this coverage, and to the extent they take advantage of the subsidy, they will be able to offer current and prospective employees a more attractive remuneration package. If their competitors in the labor market use the subsidy to attract more loyal and skilled employees, then firms that opt to provide no coverage whatsoever will find themselves at a disadvantage.

October 14, 2005

RESPONSES TO QUESTIONS FROM MR. ANTOS

Senate Subcommittee on Federal Financial Management, Government Information, and International Security

September 22, 2005 Hearing on Medicare

Prepared by Joseph R. Antos, American Enterprise Institute

1. Is there anything that Congress passed in the MMA that will put the brakes on if spending gets too high?

No. Title VIII of the Medicare Modernization Act establishes an early warning system for policymakers that would require certain actions if Medicare spending is projected to grow significantly faster than the revenue specifically designated to finance the program. The concern is that Medicare is under-funded, relying on general revenue to finance about 75 percent of Parts B and D and, in the future, a growing share of Part A spending. Rapid growth in Medicare spending puts additional pressure on the entire federal budget because of this automatic draw on general revenue, pressure that would eventually crowd out spending for other priorities such as transportation, education, and defense.

Under Title VIII, a "Medicare funding warning" would be given by the Medicare trustees if they project that general revenue would exceed 45 percent of total Medicare outlays over the next seven years, but only if the trustees made that determination in two succeeding annual reports. The early warning system does not mandate spending reductions in Medicare. Instead, the administration is required to submit legislation that addresses Medicare financing, and Congress is required to consider such legislation on an expedited basis. That legislation could include revenue increases (by raising payroll tax rates or increasing premiums paid by beneficiaries) or spending reductions. Cost-cutting legislation would not be automatically enacted.

According to the 2005 trustees report, Medicare will exceed the 45 percent threshold in 2012. If that projection remains unchanged, the trustees will issue a Medicare funding warning in 2006. A Medicare funding warning could be issued in all subsequent years unless Congress enacted substantial reform legislation. However, the warnings will not cause program spending to slow without new legislation.

2. How does MMA crowd out private sector and State drug plans? Is this for the better?

About 75 percent of Medicare beneficiaries had prescription drug coverage prior to the enactment of MMA through private insurance, Medicaid, or private plans operating under what is now called Medicare Advantage. Some beneficiaries without insurance coverage

received assistance from state and pharmaceutical company assistance programs. The new Medicare drug benefit displaces much of that coverage.

MMA prohibits continued coverage of outpatient drugs by state Medicaid programs for dual eligibles (persons who are eligible for full benefits under Medicare and Medicaid). MMA also prohibits the sale of new Medigap policies that include prescription drug coverage. The subsidized Medicare benefit will also cause more employers to drop their retiree drug coverage. Although MMA offers a subsidy to employers who retain such coverage, that subsidy is unlikely to be fully effective in encouraging employers to continue offering a drug benefit through their retiree plans.

The impact of that crowding out varies for each individual affected by Part D. Dual eligibles will be subject to only slightly higher cost-sharing requirements under Part D than they had under Medicaid, and they are likely to be subject to fewer restrictions on the pharmaceuticals they will have access to. Beneficiaries who purchased Medigap with drug coverage will receive a better benefit under Part D, and the cost of Part D premiums may be smaller than the additional premiums they would have paid for Medigap drug coverage. Those who had good retiree coverage may lose that coverage, and they are likely to face higher costs than they would have otherwise. Some retiree benefits are inferior to Part D, however. Beneficiaries who previously had no drug coverage are likely to gain under Part D if they had difficulty paying for their prescriptions.

Much of the government's outlays under Part D will be used to subsidize people with fairly high incomes or who had good prescription drug coverage. If the subsidies had been better targeted on low-income people without drug coverage, federal outlays could have been reduced or better benefits could have been provided to more low-income persons. Crowding other coverage out by Part D will result in higher federal outlays than would have been necessary otherwise, resulting in a less generous benefit for those who need the help.

3. If over 3/4 of seniors already had drug coverage before MMA, is there a need for a universal drug benefit?

Any modern health insurance program should offer prescription drug coverage to its enrollees. Medicare's failure to cover prescriptions may have skewed some treatment decisions toward more expensive approaches that were covered by the program. The clear demand on the part of seniors for more complete insurance protection has led to the proliferation of private sources of prescription drug coverage to fill in this important gap in Medicare coverage. Consequently, a universal Medicare benefit was not necessary to ensure that those of limited means without drug coverage would be able to afford appropriate drug therapies for their illnesses.

A more targeted program would have been sufficient, although the introduction of even a limited benefit would have the effect of causing beneficiaries to drop private coverage if the Medicare drug subsidies were fairly generous. In addition, there has been

a trend of declining generosity in retiree health benefits, and any limited Medicare drug benefit would have seen substantial growth in enrollment as that trend continued.

MMA included a temporary drug discount card program open to all, with a cash subsidy for low-income beneficiaries who had no other prescription coverage. Such a program could have been made permanent, and the subsidy could have been made both more generous and available to more low-income people. Had Congress chosen that approach, federal outlays would be much smaller than under Part D, and more of that money would have gone to help those with the greatest need.

4. Should we delay implementation of the drug benefit by a year or even two? Why?

A great deal of work has been completed over the past two years to implement the Medicare drug benefit. Drug sponsors, health plans, insurers, drug manufacturers, beneficiary groups, and state and federal agencies have devoted enormous amounts of money and energy to launch the full drug benefit in January 2006. Delaying Part D at this point would be highly disruptive, causing difficulties for seniors as well as the many business interests involved with the new benefit. A delay, by itself, would likely waste both resources and political good will. However, a delay coupled with a clear plan to reform the program would be worthwhile if a majority in Congress were determined to undertake the challenge.

A one-year delay is probably not feasible. Part D sponsors would have to completely re-evaluate their offerings in light of what would be viewed as precipitous action. Many sponsors—perhaps all of them—would be unable to submit bids in enough time to become operational in 2007. Contracts with manufacturers and pharmacists would have to be redrawn, and it is likely that all parties would demand higher payments to reflect the new political risks associated with Medicare. On balance, a one-year delay could *raise* the cost of the drug benefit above current projections.

A delay of two years or more does not pose the same logistical problems, and additional time to work out implementation issues could be useful. However, that time should have been built into the schedule when the law was passed. A delay of any duration imposed now would be disruptive.

If Congress delayed Part D and then established the same program with the same rules that we have now, the disruption and extra costs would simply be wasted. A delay that included a plan to institute needed Medicare reforms could be very well justified. Program changes to enhance competition and responsible consumer choice, improve incentives facing both providers and beneficiaries, and foster greater efficiency in the provision of services are needed if Medicare is to be financially sustainable in the long run.

Such reform proposals have met with strong political resistance in the past, and opposition is likely to be even greater if the drug benefit has been taken away even temporarily. Given the circumstances, it seems improbable that delaying Part D would cause Congress to enact legislation that would ensure Medicare's long-term fiscal viability.

RESPONSES TO QUESTIONS FROM MS. MOON

1. While projections of continued future GDP growth are encouraging, that growth is an assumption. In the event of a recession, will this new entitlement add trillions to our deficit?

I am not in favor of continuing to run large deficits instead of fully funding general revenue spending during periods of reasonable economic growth, such as the present. The Congress decided in 2003 that Part D of Medicare, like other important areas of government spending, should be financed by general revenues. It is important to assure that such revenues are sufficient to cover the spending that the budget calls for each year. If we were to do reduce deficits now, then in the event of a recession, Part D of Medicare would not add trillions to our deficit. Moreover, a recession is not the time to reduce spending on a program in which the need for providing coverage for prescription drugs continues.

2. You offer a tax hike as an option to cover Medicare, however, history has shown us that tax revenues actually shrink when taxes are raised. How will raising taxes increase GDP?

The supply-side theory of an inverse relationship between tax changes and tax revenues remains controversial. Moreover, it is not likely to apply in all cases even if there are instances where it occurs. Economic analysis of historical trends needs to take into account many factors and it is just as possible to point to increasing revenues as to decreasing revenues when taxes are increased. The most recent version of the Congressional Budget Office's report on options for changing spending and taxes indicates that increases in tax rates for payroll taxes, income taxes and excise taxes will all result in increased revenues over time. Like many other economists, I believe that reasonable amounts of tax increases will increase revenues and not have adverse effects on the level of GDP. Running deficits at the federal level can also be detrimental to economic growth.

3. Can we take a cue from Europe where an increased tax burden upon workers to cover entitlement spending has been accepted but per capita economic growth has actually shrunk?

Just like historical analyses within the United States, finding that higher tax burdens cause per capita GDP to shrink is a difficult task since many other factors need to be taken into account. Many of the countries in Europe with the highest rates of economic growth are also those with high tax rates. Again, I do not believe that the case is a simple one to make.

4. You argue that Medicare has done a better job at cost containment than private insurers. In achieving this, did Medicare cover the same number and type of benefits as private insurers?

* In comparing Medicare to private insurers, did you compare against plans that are comparable such as those that do not cover drugs, do not provide preventative services, do not cover disease management?

* Isn't it true that Medicare has only contained costs because it is a much less generous package than most insurers offer?

In analyzing Medicare's per capita growth rates as compared to similar rates for private insurance, we omitted prescription drugs, long term care and home health services because they are not equally covered. Disease management is an expense that cannot be reasonably separated; moreover, if it is successful, it should give an advantage to the private sector where it is more often applied. Preventive services are not a large part of spending and are unlikely to affect these figures by much if at all. The overall generosity of Medicare as compared to private plans does not affect rates of growth unless one type of benefit is a more important share than other benefits. When we looked separately at hospital spending and physician spending, for example, we continued to find better results for Medicare. For more details on the analysis I did with Cristina Boccuti, I would refer you to our article in *Health Affairs* titled "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," which was published in March/April of 2003. Moreover, similar results have been reported in several articles by the Health Expenditure Estimating Group of the Centers for Medicare and Medicaid Services and published in *Health Affairs* and the *Health Care Financing Review*.

5. Currently the government owns 43% of the drug market share. When Part D is implemented, it's estimated the market share will grow to 60%. Thus far, how has the government fared in keeping drug prices low?

Some segments of the federal government have done a good job of holding down the costs of prescription drugs—in particular the Department of Veterans Affairs. However, it is somewhat misleading to think of the government's market share since this involves many different government entities, and spending controls are often left to the private sector such as through the Federal Employees Health Benefits program.

6. In your testimony you claim that among insurance holders Medicare polls better as a provider compared to private insurance. Since no one is able to simultaneously compare private insurance and Medicare, can you please provide supporting evidence?

The polls that have been done, for example under the auspices of the Commonwealth Fund, ask individuals of all ages to rate their health insurance coverage and their satisfaction with their plans. Medicare consistently fares better than private insurance. For example, 32 % of Medicare respondents rate their insurance as excellent as compared to 20 percent of private insurance holders aged 19 to 64. And only 43% of Medicare beneficiaries report negative plan experiences as compared to 61 percent of those with private insurance. For more information, see "Medicare vs. Private Insurance: Rhetoric and Reality," Karen Davis, Cathy Schoen, Michelle Doty et al., *Health Affairs* Web Exclusive (October 9, 2002): W311–324.

7. You state that Medicare with Part D is affordable over time. Besides raising taxes, as you advocate, is there any other way to cover Medicare spending?

One way or another, someone has to pay. If Part D coverage is not provided to Medicare beneficiaries, they must pay all of the costs for prescription drugs (unless they have employer subsidized plans in which they pay some of the costs or Medicaid protection in which a combination of state and federal taxpayers have traditionally paid). The Medicare benefit will require government contributions that will cover a little more than a third of the total costs of prescription drugs, leaving the balance to be paid by individuals, their families, or employers. For the government's share, the only ways to cover government spending are through higher taxes, lower spending elsewhere or deficit spending (which postpones until later who will pay). I believe the most honest way to cover a benefit that a majority of Congress voted for and that has strong taxpayer support is to do so through higher taxes.

8. Please provide a citation for your claim that Medicare pays 55% of the costs of the acute health care costs. Where did you get that information?

This figure has been used many times and shows up in many publications. The most recent "official" figures indicate that the number is 53% (from CMS.gov) or 54% from the Medicare Payment Commission's 2005 data book, also available on line.

9. You mentioned that the Trustees reported a 66% increase in per worker GDP after controlling inflation. How would workers be 57% better off than they are today if per capita GDP was lowered, as you claim? Please cite your figures and explain your claims.

The numbers I cited are from calculations I made using data from the 2005 Trustees' reports on Medicare and Social Security. The measure begins with computing per worker GDP over time, resulting in a measure of the nation's output of goods and services divided across the working population. This provides the base for assessing Medicare's burden on workers, who pay for the bulk of support for the program. Per worker GDP—even after adjusting for inflation—rises substantially, from $74,914 per worker in 2005 to

over $124,421 in 2035 (in 2004 dollars). This is an increase of 66.1 percent in per worker GDP, a substantial increase in financial well-being.

To calculate the per worker burden from Medicare, several adjustments are necessary. First, each worker will bear an increasing share of Medicare over time because of the change in the ratio of workers to retirees. Further, per capita Medicare costs are expected to rise faster than GDP by 2035, also increasing the real dollar burden on workers. But not all of Medicare's costs are borne by workers. Costs are adjusted downward by projected beneficiary contributions. The Part B and D premiums are one financing source netted out of the total. In addition, beneficiaries make further contributions because some of the taxation of Social Security benefits goes into Part A and older and disabled persons also pay income taxes that help support Parts B and D. So those costs also need to be netted out.

The resulting real per worker burden estimates range from $1,906 in 2005 to $7,303 per worker in 2035. After subtracting these burdens from per worker GDP, the net growth in per worker GDP falls to 57.2 percent. That is, workers would still be substantially better off than today, even after paying the full projected costs of Medicare with the prescription drug benefit.

My forthcoming book, *Medicare: A Policy Primer*, from the Urban Institute Press will contain a more detailed description of the calculations for these newer figures. An older version of these calculations is available from the website of the Kaiser Family Foundation in a paper entitled, "Solvency or Affordability? Ways to Measure Medicare's Financial Health" of which I was a co-author.

10. You disagreed that people can't make decisions based on value, that if they are ill, they will pay for health care, with no regard to price or outcome. Are you saying that price and outcome have no influence in one's decision about his health care? Do you have evidence to support this?

Many health care analysts have recognized that above a certain level of spending on health care, it is difficult to expect people, who are sick and under stress, to make price comparisons or seek multiple opinions on treatment. For people of all ages (including Medicare beneficiaries) about 75% of health care spending is attributable to just 5% of the population. And that spending often occurs in these high pressure situations. For others, who are in a better situation to respond to price or outcome information, many studies show that people have difficulty doing so. The most famous of these is the Rand health insurance experiment which found that although higher cost sharing reduced spending, needed health services were just as likely to be reduced as more questionable ones. Better information can help, and should be offered to consumers, but putting more "skin in the game" is not likely to pay off as well as many advocates of that approach believe.

11. As an economist who advocates a single payer system, what will happen to innovation in the medical drug and device industry and the health care industry in general if we move to central planning? Do you view market forces in the American private health care sector as having any benefit to consumers? If so, what?

I do not necessarily advocate a single payer system since as I indicated in my testimony that I believe that Americans are not likely to accept such a system. On the other hand, a single payer system could be designed that would be fairer and more efficient than the system we have now. It does not necessarily come with "central planning." Indeed, I have seen very few plans that would move in that direction. The key to innovation in health care is for the industry to believe that it will be fairly compensated in the future for new innovations. That is certainly feasible in a single payer system. In fact, it may become increasingly difficult without a system that assures that low and moderate income Americans can afford these new innovations.

RESPONSES TO QUESTIONS FROM MR. GOKHALE

Q1. When MMA is implemented, the federal government's market share of the drug market will be 60%. How will this affect drug prices?

MMA will expand the government's share of the prescription drug market from the current 20 percent to 60 percent. Such a large increase in the government's market share will increase drug price inflation considerably. The increase in private market drug prices would be the main mechanism whereby private market demand for drugs would be reduced to accommodate the increase in demand from government subsidized patients.

The government's drug market share would increase as a result of increased drug demands from two types of individuals. The first type would include those with no current drug coverage (about 25 percent of retirees) and who would now receive a government drug subsidy. Their demand for drugs would represent a net increase. The second type includes those for whom Medicare's drug coverage would be broader than their current private coverage -- such as those who purchase Medigap insurance. The more extensive Medicare drug coverage for both types of individuals would induce them to increase their use of prescription drugs. Finally, doctors are likely to increase their frequency of prescribing drugs once MMA is fully implemented, because many of their patients would now face lower out-of-pocket drug costs.

Medicare Part D is prohibited from using its potential market power as a large drug purchaser to force lower-than-market prices on drug manufacturers. Instead, prices paid by the government to drug providers will be negotiated between the providers (manufacturers and pharmacies) and the sponsors of prescription drug plans. Although the hope is that competition between drug providers will depress drug prices, such an outcome is not guaranteed. Prices of patented drugs with few substitutes are unlikely to be reduced. Indeed, competition between prescription drug plan sponsors for limited drug supplies may cause drug prices to be bid higher.

In order to elicit a net increase in the supply of drugs, prescription drug plan sponsors may have to increase the prices paid to manufacturers and pharmacies. Consequently, the prices charged to private market drug purchasers would also increase. As a result, employers and other private providers of prescription drug coverage would be forced to increase plan premiums and cost sharing, which would tend to shrink private demand for prescription drugs.

This crowding out of private purchasers will have several effects. First, those retirees who initially chose to remain under their existing coverage (private employer or Medigap) would be induced to switch to Medicare Part D—further increasing the government's market share. Second, the cost of health care coverage for workers would increase as drug prices rise, reducing their wages, likelihood of employment, the availability of full-time jobs, and the number of workers without health insurance.

The theoretical expectation of an increase in drug prices following the implementation of MMA is supported by empirical evidence. A study covering 200 drugs during 1997 and 2001 found that government participation in the drug market through Medicaid significantly increased drug prices faced by non-government payers.[1] An increase in the government's market share by 10 percent was found to be associated with a 10 percent increase in the drug's price in 2002. This finding remains valid despite the addition of several controlling factors such as drug therapeutic classes, the existence of generics, the number of close substitutes for the drug in question, and the time elapsed since the drug's first introduction. Considering Medicaid's market share in the top 200 drugs, the study suggests that private-market drug prices would have been lower by 13.3 percent, on average, in the absence of Medicaid.

To be fair, the empirical study cited above studies the relationship between the government's drug market share and private market drug prices under Medicaid. Those

[1] See "The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing," by Mark Duggan and Fiona Scott Morton, National Bureau of Economic Research, Working Paper No. 10930.

results could have arisen because of the particular pricing strategy adopted by the government under Medicaid. However, there is little reason to believe that drug price outcomes would be much different under the "competitive bidding" framework envisioned under Medicare, Part D. Competitive bidding among plan sponsors may dominate the competition between drug manufacturers, especially for drugs that are in limited supply -- resulting in higher, rather than lower drug prices. The likelihood of much greater prescription drug usage by retirees following MMA's implementation is likely to result in considerably larger overall demand for prescription drugs and a much faster inflation in prescription drug prices in the future.

Q2. The President has a plan for reducing the deficit by half in the next five years. But what happens after that? Will we be able to sustain defense and entitlement spending, services Americans expect or have been promised from their government? Is the $8.7 trillion Part D shortfall sustainable?

Reducing the deficit to half from its current level in 5 years by cutting federal spending is a laudable objective. Achieving that goal will reduce the amount of resources that the federal government absorbs, thereby making more resources available for private domestic investment.

However, restricting attention to the next 5 years when making budget policy is inappropriate because federal deficits are projected to increase rapidly and for a sustained period after the end of the 5-year budget window. Those higher deficits will accrue when soon-to-retire baby boomers begin to claim their Social Security and Medicare benefits.

Adopting a longer-term view, Social Security and Medicare are projected to accrue financial shortfalls of $33.7 trillion over the next 75 years.[2] These are the official

[2] The $33.7 trillion figure is the sum of the 75-year unfunded obligations of Social Security and Medicare, Part A, and the general revenue transfers required during the next 75 years for Medicare, Parts B, and D -- as reported by those programs' Trustees in their annual reports.

estimates of the Social Security and Medicare Trustees; they include only revenues dedicated to those programs and are measured as present discounted values using interest rates earned on the Treasury securities held in those programs' trust funds. The new Medicare prescription drug coverage accounts for $8.7 trillion of the $33.7 trillion total 75-year financial shortfall.

Maintaining policies that imply such massive unfunded obligations is fiscally imprudent. They imply huge accruals to federal debt, massive increases in federal taxes, deep cuts in federal programs other than Social Security and Medicare, or some combination of these, commencing just beyond the 5-year budget window.

If tax hikes were implemented, higher taxes would dilute work incentives, lower labor force participation, and reduce national output. Because of their output reducing effect, tax hikes, no matter how high, would fail to raise the required revenues. On the other hand, deficit financing future entitlement outlays would drain the economy of investible resources. Given today's low level of private saving, such high deficits would require dissaving—that is, the sale of the national capital stock for financing entitlement benefits.

Future unfunded obligations are similar to outstanding federal debt; their size grows larger through interest accruals. At the discount rate used by Social Security and Medicare actuaries (6 percent per year), the interest cost accruing annually on the 75-year unfunded obligations of $33.7 trillion is $2 trillion. Because the national economic growth rate is smaller than the interest rate, our capacity to pay this interest cost worsens each year that unfunded entitlement obligations remain unresolved. Failure to resolve these obligations earlier implies larger and more difficult policy adjustments later.

If future entitlement obligations are not reduced, if taxes cannot be increased to pay for them, and if deficit financing is ruled out, federal non-entitlement programs would have to be cut. Although some spending cuts may be possible already regardless of the future budget situation, the severe program cuts necessary to resolve existing

unfunded obligations will leave the economy without adequate defense, homeland security, law enforcement, and public infrastructure and so on, which would, again, erode private sector productivity and national output.

How deep would those cuts have to be? The answer is straightforward. In present discounted value terms, cuts in federal outlays on programs other than Social Security and Medicare must equal those programs' unfunded obligations. Using consistent estimates on the two items with projections extending through 2079, the required cut equals 49.5 percent. Excluding Medicare's prescription drug coverage, the cut needed would be 29.2 percent.

This suggests that the addition of Medicare's prescription drug program to federal unfunded obligations implies an additional across-the-board cut in non-Social Security and non-Medicare outlays of 20.3 percentage points (if tax hikes and deficit financing are both ruled out through the next 75 years). Thus, Medicare's prescription drug program has made an already dire future budget situation much worse. Timely decisions are required to reduce or downsize federal entitlement commitments, including those under Medicare's prescription drug coverage.

Q3. How will expanding the Medicare entitlement to include prescription drugs affect national saving? What are the consequences of such an effect?

The new prescription drug program adds an unfunded benefit to Medicare. Although the federal government has increased its future spending commitment, it has not explicitly earmarked resources to finance it. Instead, the cost of retiree prescription drug coverage would be financed out of general revenue transfers to the Medicare trust fund. Without concomitant changes in taxes, however, exactly how the federal government would collect the required resources is uncertain.

For current generations, and especially for current retirees, certainty regarding additional future benefits but uncertainty regarding additional future taxes represents a net increase in disposable resources. That addition to resources would directly induce higher consumption by their recipients.

For current retirees, this effect is well documented. With the government paying a larger share of their prescription drug costs, retirees would devote more of their own resources toward other consumption items. Evidence from survey data (noted in earlier testimony) shows that older generations' consume more out of disposable resources compared to younger ones. Moreover, today's retirees are consuming their resources at a faster rate compared to retirees a few decades ago.

For workers, too, the perception that some of their benefits may be free—that is, may accrue without a corresponding tax burden—means that they can save less for funding drug costs during retirement. However, the net benefit per capita accruing to *younger* workers is likely to be smaller than that accruing to people about to retire because the former are likely to bear a larger burden of financing Medicare's drug coverage. That would be the case even if the new benefit is deficit financed instead of financed out of higher taxes. Higher deficits would erode net domestic investment and reduce younger workers' productivity and wages. They would also bear the additional burden of higher private market drug prices, which would increase their health insurance costs.

The Medicare Trustees estimate the unfunded cost of Medicare prescription drug coverage will be 8.7 trillion over the next 75 years. Of this, the expected net benefit accruing to generations currently alive is expected to be $6.7 trillion. That is, maintaining this policy through the next 75 years – which approximates the remaining lifespan of the youngest workers alive – would increase current generations' resources by $6.7 trillion.

By how much would this windfall increase consumption over the next 75 years? A Congressional Budget Office study reviewed academic literature on this question and

concluded that for every $1 increase in federal unfunded entitlement obligations, national saving declines by 0 to 50 cents.[3]

That wide range indicates the considerable uncertainty surrounding such estimates. However, it suggests that even the best estimate of the MMA's impact on national saving is negative. Taking the mid-point of the range -- 25 cents -- national saving may be expected to cumulatively decline by $1.7 trillion by the time today's youngest generations complete their life cycles. That is, by 2079 the national capital stock would be smaller by $1.7 trillion and future Americans' productivity and living standards would be correspondingly lower.

Q4. How could the country benefit if we delayed implementation of Part D by a year or even two? Should we go ahead as scheduled for January 1, 2006?

Implementing Medicare's prescription drug benefit confers benefits on current generations but hurts future ones. Hence, postponing its implementation by a year or two would reverse those effects to a small degree.

By delaying implementation, the country would also postpone the negative economic effects of Medicare Part D. The inflationary pressure on drug prices would not begin as early or be as intense. Hence, the expected negative impact on workers' wages, employment, and health insurance would also be delayed. Delaying implementation would also reduce national consumption and maintain national saving at higher levels.

However, if delaying implementation by a year or two makes sense, delaying it by a further year or two would make even more sense...and so on. In short, repealing Medicare Part D would make the most sense from a national perspective.

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[3] See "Social Security and Private Saving: A Review of the Literature" Congressional Budget Office, July 1998.

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