

Testimony of Beatrice Braun, M.D., AARP Board Member

Mr. Chairman and members of the Committee, I am Beatrice Braun, a member of AARP's Board of Directors. I appreciate the opportunity to share with you AARP's perspective on some of the broader issues involved in reforming the Medicare program, and in particular, on the need for Medicare prescription drug coverage.

For over thirty years Medicare has provided older and disabled beneficiaries with dependable, affordable, quality health insurance. I live in Florida, which has one of the largest beneficiary populations in the nation. As a retired physician, I have seen first hand how Medicare has made a difference in the lives of older Americans. Medicare has been instrumental in improving the health and life expectancy of beneficiaries in Florida and across the nation. It has also helped to reduce the number of older persons living in poverty.

Medicare's promise of affordable health care extends beyond the current generation of retirees. Now, more than ever, Americans of all ages are looking to Medicare's guaranteed protections as part of the foundation of their retirement planning. AARP believes that in order for Medicare to remain strong and viable for today's beneficiaries, and for those who will depend on it in the future, we must confront the key challenges facing the program.

Foremost among these challenges is ensuring that Medicare's benefits and its means of delivering care remain dependable even as they are updated to keep pace with the rapid advances in health care. The practice of medicine has changed dramatically since the Medicare program was created. We are now living in a time of amazing breakthroughs in medical technology. Each time I pick up a newspaper or turn on the television there are stories about new procedures or therapies that could improve the lives of millions of Americans. Among the most striking are the advances in the area of prescription drugs. Drug therapies that were not available when Medicare began are now commonly used to prevent, treat, and control illnesses. As a result, prudent reliance on prescription drugs now goes to the very core of good medical practice.

Ironically, while older Americans typically need more medications than younger people, most employer plans include and rely on prescription drug coverage as an essential tool for medical management, but Medicare still does not. Prescription drug coverage must be part of an improved Medicare program. Simply stated, prescription drug coverage is smart medicine.

The second challenge facing Medicare is our nation's changing demographics. The retirement of the baby boom generation will nearly double the number of Medicare beneficiaries in the program. Medicare's financing and delivery systems must be capable of serving this enormous influx of beneficiaries whose health care circumstances, needs, and expectations will be similar in some respects to those of today's beneficiaries, but very different in others. Just as important, longer life spans are already causing rapid growth in the very old population. Medicare must be prepared to handle the unique health care needs of a growing number of older Americans who reach 85, or even 100.

To meet the first two challenges, the program's long-term financial solvency must be secure. AARP supported the Balanced Budget Act of 1997 as a first step towards securing Medicare's long-term solvency. The strong economy we now enjoy, and the Medicare Trustees' projection of solvency to the year 2015, is good news. But, this does not mean we can afford to become complacent or that we can delay the debate over how best to strengthen Medicare.

The deliberation over Medicare's future must be ongoing. It will take a sustained effort to continually

update and improve Medicare. Changing a program that millions of Americans depend on for their health care is no small task. There must be a careful and thorough examination of the full range of issues - including how the issues interact and impact beneficiaries - and a similarly careful effort to make sure that policy makers and the public alike understand the trade-offs that will be necessary.

The competitive premium proposal introduced by Senators Breaux and Frist, the President's proposal, and other emerging legislative proposals, provide opportunities for examining different reform options and for stimulating debate. Genuine debate over the issues and options surrounding Medicare are critical to building public understanding and support for reform. **AARP believes that it would be a serious mistake for anyone to hinder debate on such proposals or, by the same token, for Congress to rush to judgment on any reform option.**

Lessons Learned

As promising reform options emerge, it is only reasonable to test those ideas so we more fully understand the impact on Medicare beneficiaries and the program in general. A high priority must be to ensure that reform proposals actually work, and cause minimum disruption for beneficiaries and Medicare. Whenever possible, changes to Medicare should be tested and evaluated on a smaller scale before being incorporated into the full program. Pilot testing can help to identify potential problems and provide the opportunity for making necessary refinements before the changes are made program-wide.

Further, it is important that changes be given time to be assimilated into the program, and their impact be assessed, before new modifications are layered on top. Every change to Medicare will bring unintended consequences. Only two years after enactment of the sweeping changes made by the Balanced Budget Act (BBA) of 1997 many of which were still being implemented -Congress significantly modified these provisions with passage of the Balanced Budget Act Revisions of 1999. Mid-course changes of this magnitude can create administrative complexities as well as confusion and disruption for Medicare's nearly 40 million beneficiaries. Policy makers and the public must understand proposed changes and their anticipated effect, first and foremost on beneficiaries, but also on providers and on the Medicare program in general. As we all learned from the legislative debates over the recent BBA revisions, earlier experiences with the Catastrophic Coverage Act in the late 1980s, and from the health care reform debate of the early 1990s, unless the American public understands the trade-offs they are being asked to make, initial support can erode quickly.

The Need for a Medicare Prescription Drug Benefit

This Committee plays an important role in identifying issues of concern to older Americans. AARP hopes today's hearing will help focus attention on the need for a Medicare prescription drug benefit as well as other Medicare reform issues.

Pharmaceutical therapies have become increasingly important in the treatment of virtually every major illness. In many cases, new drugs substitute for or allow patients to avoid more expensive therapies such as hospitalization and surgery. In other cases, drugs facilitate treatment or provide treatment where none existed before, thus improving the quality and length of life for the patient. Breakthroughs in prescription drug treatments are happening in many areas. From Alzheimer's and arthritis to heart disease and the flu, new prescription drugs are becoming available to treat and even prevent serious conditions and life-threatening illnesses.

The need for prescription drug coverage is especially important for older Americans. Eighty percent of retirees use a prescription drug every day. While older Americans comprise only 12 percent of the U.S.

population, they account for one-third of prescription drug spending. In fact, prescription drugs account for the single largest component of health care out-of-pocket spending, after premium payments, for noninstitutionalized Medicare beneficiaries age 65 and older. On average, these beneficiaries are expected to spend as much out-of-pocket for prescription drugs (17 percent of total out-of-pocket health care spending) as for physician care, vision services, and medical supplies combined. By contrast, inpatient and outpatient hospital care each accounts for about 3 percent of older beneficiaries' total out-of-pocket health spending.

High use, high drug prices, and inadequate insurance coverage pose serious problems for today's Medicare beneficiaries. In fact, some beneficiaries are forced to choose between food and their medications. Others do not refill their prescriptions or take the proper dosage in order to make their prescriptions last longer. A chronic health problem necessitating some of the newest, most expensive prescription drugs can deplete a retiree's financial resources.

Because of Medicare's current lack of prescription drug coverage, many beneficiaries must pay for prescription drugs completely out-of-pocket. Other beneficiaries obtain private supplemental coverage that assists with costs or join a Medicare HMO that offers a prescription drug benefit. It is also important to understand that those Medicare beneficiaries without coverage pay top dollar for their prescriptions because they do not benefit from discounts negotiated by third party payers as do most younger persons.

Although 65 percent of Medicare beneficiaries have *some type* of coverage for prescription drugs, this figure can be very misleading. Many current prescription drug coverage options are inadequate, restricted, expensive, and unstable. In fact, the majority of Medicare beneficiaries -not just those with low incomes - need drug coverage. Why?

First, Medicare beneficiaries' current prescription drug coverage does not protect them from high out-of-pocket expenses. AARP estimates that 25 percent of Medicare beneficiaries spent over \$500 out-of-pocket on prescription drugs in 1999, and over half of these beneficiaries had some type of coverage. Forty-two percent of beneficiaries who spent \$1,000 or more had some type of drug coverage. For example, some beneficiaries buy Medigap policies that provide a drug benefit. But, the premiums on these policies often exceed \$1,000 a year and the coverage is quite limited. Two of the three Medigap policies that cover prescription drugs have an annual cap of \$1,250 on drug coverage; the third policy has a \$3,000 cap. All three Medigap policies that have a prescription drug benefit require the beneficiary to pay 50 percent coinsurance. Other beneficiaries choose to enroll in Medicare HMOs that offer some prescription drug coverage. Yet, this year 32 percent of Medicare HMOs offering drug coverage have a \$500 cap that applies to brand or brand and generic drugs, and average copays in these plans have increased dramatically from last year - an estimated 21 percent for brands and 8 percent for generics.

Second, current prescription drug coverage available to Medicare beneficiaries is limited. Private Medigap policies may be the only option for obtaining drug coverage for beneficiaries who do not have access to employer coverage or Medicare+ Choice plans. Yet, because almost all Medigap policies with drug coverage are medically underwritten, many Medicare beneficiaries desiring such coverage cannot obtain it. Although Medicare HMOs are prohibited by law from underwriting the coverage they offer, such plans are not available in all parts of the country.

Third, current drug coverage options are not stable. For example, beneficiaries who obtain prescription drug coverage from their former employer are finding that coverage to be unstable. Retiree health benefits that include prescription drug coverage are becoming more scarce. While an estimated 60 to 70 percent of large employers offered retiree health coverage during the 1980s, fewer than 40 percent do so today. Of those employers who offer retiree benefits, 28 percent do not offer drug coverage to Medicare eligible retirees.

Further, beneficiaries who have drug coverage through Medicare HMOs cannot depend on having this coverage from year to year as their plans can change their benefits on an annual basis or even terminate their participation in Medicare. For example, this year many beneficiaries in Medicare+Choice plans are living through abrupt changes in their prescription drug coverage that they did not foresee when they enrolled. Some of the most visible of these changes include:

- Increasing premiums - Over the past few years, more and more Medicare+ Choice plans are charging premiums for their coverage, and those premiums are climbing. This year 207,000 beneficiaries must pay over \$80 per month to enroll in a Medicare HMO. This compares to 1999 when only 50,000 Medicare beneficiaries enrolled in Medicare HMOs had a minimum premium above \$80 per month.
- Higher cost-sharing - For the first time this year, all Medicare HMOs are charging copays for prescription drugs and the average beneficiary copay has increased significantly.
- Decreasing benefit -The annual cap on the typical Medicare +Choice drug benefit has decreased. While in 1999 only 21 percent of Medicare HMOs had an annual cap of \$500 or less on their drug benefit, this year 32 percent of plans will have a \$500 cap.
- Loss of benefit - This year some Medicare+Choice plans dropped their prescription drug benefit entirely. Although Medicare+ Choice has provided beneficiaries with an opportunity for drug coverage, the volatility of the Medicare+Choice market has made that coverage unpredictable and unstable from year to year.

Finally, as reported in a new study by the Commonwealth Fund, many Medicare beneficiaries do not have continuous prescription drug coverage. In 1996, just 53 percent of beneficiaries had prescription drug coverage *throughout* the year.

Issues Surrounding Adding Prescription Drugs to Medicare

AARP is committed to creating an affordable Medicare prescription drug benefit that would be available to all beneficiaries, so that they may benefit from longer, healthier lives, fewer invasive medical procedures, and reduced health care costs. We appreciate the Committee's interest in this issue and look forward to working with the Congress and the Administration to assure that a prescription drug benefit that is available and affordable to all Medicare beneficiaries becomes part of Medicare's defined benefit package. To that end, we have identified what we believe are the fundamentals of a Medicare prescription drug benefit:

- A Medicare prescription drug benefit must be **available** to **all** Medicare beneficiaries. First, the benefit should be *voluntary* so that beneficiaries are able to keep the coverage that they currently have, if they choose to do so. A Medicare prescription drug benefit should not be an incentive for employers to drop or cut back on retiree health coverage. Second, the benefit needs to be *affordable* to assure enough participation and thereby avoid the dangers of risk selection. To this end, the government contribution will need to be sufficient to provide a premium that is affordable, and a benefit design that is attractive to beneficiaries. In other words, this is not simply a matter of beneficiary affordability, but equally important, the fiscal viability of the risk pool. Medicare Part B is a model in this regard. The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation.
- Prescription drugs should be part of a defined benefit package. It is critical that beneficiaries understand what is included in their benefit and that they have dependable and stable prescription

drug coverage.

- The benefit must assure beneficiaries have access to medically appropriate and needed drug therapies.
- The benefit must include quality improvement components to reduce medical errors and mismedication and to help reduce overall health care costs.
- The benefit must include meaningful cost-containment mechanisms for both beneficiaries and Medicare. This should include drug-purchasing, strategies that enable Medicare beneficiaries and the program to take advantage of the aggregate purchasing power of large numbers of beneficiaries.
- The benefit must provide additional subsidies for low-income beneficiaries to protect them from unaffordable costs and assure that they have access to the benefit.
- The benefit must be financed in a fiscally responsible manner that is both adequate and stable. AARP believes that an appropriate amount of the Federal budget surplus should be used to help finance a prescription drug benefit.
- A new prescription drug benefit should be part of a strong and more effective Medicare program. Prescription drug coverage must be integrated into the program in a manner that strengthens Medicare. Prescription drug coverage must also improve Medicare's ability to support modern disease management and prevention strategies. Many of these strategies hold promise to both increase health outcomes and lower program costs.

Key Principles That Should Guide Broader Medicare Reform

As this Committee also examines the broader issue of reforming Medicare, AARP urges you to consider the fundamental principles that, since Medicare's inception, have helped to shape it into such a successful program. We believe strongly that these principles must be the basis of any viable reform option.

Defined Benefits Including Prescription Drugs

All Medicare beneficiaries are now guaranteed a defined set of health care benefits upon which they depend. A specified benefit package that is set in statute is important for a number of reasons. First, it assures that Medicare remains a dependable source of health coverage over time. Second, a defined benefit package serves as an important benchmark upon which the adequacy of the government's contribution toward the cost of care can be measured. Without this kind of benchmark, the government's contribution could diminish over time, thereby eroding Medicare's protection. Third, a benefit package set in statute reduces the potential for adverse selection by providing an appropriate basis for competition among the health plans participating in Medicare. And finally, a defined benefit package provides an element of certainty around which individuals, employers, and state Medicaid programs may plan.

As was laid out earlier in this statement, because prescription drugs are central to the delivery of high quality health care, Medicare should be like most other health insurance plans and include prescription drugs as part of Medicare's defined benefit package offered by all participating plans - including traditional fee-for-service.

Adequate Government Contribution Toward the Cost of the Benefit Package

It is essential that the government's contribution or payment for the Medicare benefit package keep pace over time with the cost of the benefits. Currently, payment for traditional Medicare is roughly tied to the cost of the benefit package. If the government's contribution were tied to an artificial budget target and not connected to the actual cost of the benefit package, there would be a serious risk of both the benefits and government payment diminishing over time. The effect of a flat government payment - regardless of the plan cost - could be sharp year-to-year premium and costsharing increases for beneficiaries. It could also mean significant differences in what beneficiaries would have to pay for different Medicare plans.

Out-of-Pocket Protection

Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs. Medicare beneficiaries age 65 and over, spent on average, about \$2,430 - nearly 20 percent of their income - out-of-pocket for health care expenses in 1999, excluding the costs of home care and long-term nursing care. In addition to items and services not covered by Medicare, beneficiaries have significant Medicare cost-sharing obligations: a \$100 annual Part B deductible, a \$776 Part A hospital deductible, 20 percent coinsurance for most Part B services, a substantially higher coinsurance for hospital outpatient services and mental health care, and significant coinsurance for skilled nursing facility care and very long hospital stays. Currently, there is no coinsurance for Medicare home health care.

AARP believes that Medicare beneficiaries should continue to pay their fair share of the cost of Medicare. However, if cost-sharing were too high or varied across plans, Medicare's protection would not be affordable, and many beneficiaries would be left with coverage options they might consider inadequate or unsatisfactory.

Viable Fee-for-Service

Medicare beneficiaries must continue to have access to a strong and viable fee-for-service option. Managed care is not yet established as a fully satisfactory choice for many beneficiaries. In addition, many beneficiaries live in areas of the country where managed care plans are not available or likely to become available soon. Without an affordable fee-for-service option, these beneficiaries could end up paying as much or more out-of-pocket for health care coverage that does not meet their needs.

Protecting the Availability and Affordability of Medicare Coverage

Medicare should continue to be available to all older and disabled Americans regardless of their health status or income. Our nation's commitment to a system in which Americans contribute to the program through payroll taxes during their working years and then are entitled to receive the benefits they have earned is the linchpin of public support for Medicare. Denying Medicare coverage to individuals based on income threatens this principle. Similarly, raising the age of Medicare eligibility would have the likely effect of leaving more Americans uninsured. Thus, in the absence of changes that would protect access to affordable coverage, AARP views it as unacceptable to raise the eligibility age for Medicare. Analogies to Social Security's increasing age of eligibility simply do not apply. Social Security's early retirement benefits - though actuarially reduced - start at age 62, and most retirees today begin to collect benefits at age 62 not at age 65.

Administration of Medicare

Effective administration of the program remains essential. The agency or organization that oversees Medicare must be accountable to Congress and beneficiaries for assuring access, affordability, adequacy of coverage, quality of care, and choice. It must have the tools and the flexibility it needs to improve the program - such as the ability to try new options like competitive bidding or expanding centers of excellence. It must ensure that a level playing field exists across all options; modernize original Medicare fee-for-service so that it remains a viable option for beneficiaries; ensure that all health plans meet rigorous standards; and continue to rigorously attack waste, fraud and abuse in the program.

Financing

Medicare must have a stable source of financing that keeps pace with enrollment and the costs of the program. Ultimately, financing sources will need to be both broadly based and progressive. Additionally, because health care costs are rising faster than productivity, AARP supports using an appropriate portion of the on-budget surplus to secure Medicare's financial health.

The Breaux-Frist Proposal

We have not attempted in this testimony to undertake an extensive review of the Breaux-Frist proposal, and the full range of questions that it raises. That essential step will require many more hearings, close review by a range of experts, and careful assessment of the impact of the proposed changes on Medicare beneficiaries, plans and providers, and the program itself.

AARP commends Senators John Breaux and Bill Frist for their efforts to ensure that Medicare reform remains a priority. While critical questions remain, S. 1895 includes several improvements over earlier versions of the proposal, including a modest (at least 25 percent) subsidy for all beneficiaries who choose to take the high option plan with prescription drugs. Among the fundamental questions that must be answered and their impact assessed are:

- How and to what extent would S. 1895 improve Medicare's long term solvency?
- Medicare beneficiaries who elect to stay in the HCFA-sponsored program would be guaranteed a defined benefit that includes Medicare's current benefits. However, beneficiaries who choose other plans could experience "reasonable variation in costsharing." What constitutes "reasonable variation" and how would this affect beneficiaries? Would this difference between the HCFA-sponsored plan and other plans put the traditional Medicare fee-for-service program and its beneficiaries at risk?
- To what extent will the government contribution assure adequate choice for beneficiaries over time, without regard to where they live? Is the prescription drug benefit affordable? Is a 25 percent premium subsidy enough to make the benefit affordable for most beneficiaries and to assure a viable risk pool?
- Because the drug benefit would be pegged to actuarial cost and not to a particular benefit design (e.g., deductible, cost sharing, stop-loss protection, etc.), it appears that the drug benefit could be designed in different ways by different high option plans. How, then, would insurers be prevented from "cherry picking" beneficiaries through the design of their drug benefit?
- How will the proposal protect beneficiaries who live in high cost areas where all high option plans have premiums above the national weighted average?
- Because the high-option stop-loss protection does not extend to the prescription drug benefit, how

would beneficiaries who have very high drug costs be protected?

- S. 1895 relies heavily on risk adjusters to assure appropriate payment to plans. Given that dependable risk adjustment is still in development - and probably will be for some time - how would risk and geographic adjusters be calculated? How would appropriate payment to plans be calculated prior to the development of fully functional risk adjusters?
- To whom would the new Medicare Board be accountable? How much discretion would the Board have in making changes in program policy to respond to changing market conditions?
- What is the rationale for establishing a new "solvency standard?" The bill would cap Medicare general revenue at 40% of Medicare spending. What would be the impact of this general revenue spending cap on payments to providers and plans? On beneficiaries' premiums, cost-sharing, and/or benefits? How would this be determined? What would be the impact of this cap on Medicare's entitlement?
- As a practical matter, how would premiums that vary by plan be deducted from individual Social Security checks? Would this be administratively feasible?

Because the Breaux-Frist proposal continues to be refined, AARP is reserving final judgment on the plan until further questions about its impact on Medicare beneficiaries and the Medicare program are answered.

Conclusion

The Medicare program needs to be ready to meet the unique challenges it now faces now and in the future. Foremost among the challenges is ensuring that, even as the program adjusts to ensure its future financial soundness, it must also adjust to keep pace with the rapid advances in medicine. Therefore, AARP believes that an affordable Medicare prescription drug benefit that is part of Medicare's defined benefit package and available to all Medicare beneficiaries is essential to any Medicare reforms.

Finally, the success of any changes to Medicare and the long-term strength and stability of the program depend on a good understanding - on the part of the public and policy makers alike - of the changes that are being contemplated. This will require not only extensive dialogue, but also a thorough analysis of how the proposed changes would affect current and future beneficiaries -including the chronically ill, the poor and near-poor, and those who live in rural America.

If legislation is pushed through too quickly, before there has been a thorough examination of the effect on beneficiaries and the program, and before there is an emerging "public judgment" about the changes, this would be a very serious mistake. In such a circumstance, we would be compelled to alert our members to the dangers in such legislation and why we could not support it.

AARP looks forward to continuing to work with members of this Committee and the Congress to advance the debate over Medicare reform and prescription drug coverage, and to carefully explore the best options for securing Medicare's future.