

Ask the Experts: Medicare Prescription Drugs October 15, 2003

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LARRY LEVITT: This is Larry Levitt from kaisernetwork.org, and welcome to our inaugural "Ask the Experts" show. This is your chance, whoever you are and wherever you are, to gain access to some of the nation's top health policy experts. Our topic today is the Medicare prescription drug debate. Possibly the largest health policy debate we've seen in this country in at least a decade. Depending on who you ask, we may be poised for a major, and some would say overdue, expansion of the Medicare program. Or ready to embark on a four hundred billion dollar entitlement expansion that the nation can't afford. Or as we enter an election year, finding ourselves talking a lot about this issue, but in the end with no bill on the President's desk.

The state of play as of today is as follows: approximately a third, over a third, of Medicare beneficiaries lack prescription drug coverage. Each of the House and the Senate have passed bills with plans to add a prescription drug benefit to Medicare. That was several months ago. In the intervening months, a legislative conference committee has been meeting to reconcile the differences between these bills. This conference committee has worked out some of the issues and yet on others they are seemingly deadlocked at times. Congressional leaders set October seventeenth, that's the end of this week, as a deadline to reach a compromise on this legislation. Most I think, believe that this deadline will

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pass without such a compromise although it remains unclear whether anything will happen if the deadline is missed. For the next hour, you will be able to ask any question you may have about this Medicare reform legislation. How would the legislation work? How would it affect seniors? Why is Congress taking one approach over another? You can reach us here in the Kaiser Family Foundation broadcast studio in two ways, either send an e-mail to ask@kaisernetwork.org, that's ask@kaisernetwork.org, or call us and ask your question on the air. You can reach us by phone at 888-KAISER-8, that's 888-524-7378.

To help us sort out the issues in this debate, we're joined here in the studio by three of the nation's experts on Medicare. Marilyn Moon is Vice-President and Director of Health at the American Institutes of Research and previously served as a trustee for the Medicare and Social Security Trust Fund. Joe Antos is a scholar at the American Enterprise Institute and previously directed health programs at the Congressional budget office, the arbiter in Washington for everything budgetary and, in Washington, pretty much everything is budgetary. And finally Tricia Neuman, Vice-President of the Kaiser Family Foundation and Director of the Medicare Policy Project at the Foundation. Tricia also served on the professional staff of the House Ways and Means subcommittee on health and the Senate committee on aging.

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Tricia, let's start with you. Obviously the root of this debate is adding a drug benefit to the Medicare program. It sounds like a simple proposition, but in fact these bills are hundreds of pages long and anything but simple. Describe for us what seniors would get as a drug benefit in these bills and how they would get that coverage.

TRICIA NEUMAN: Well the first thing they would get is a discount card in 2004 and that's in both the House and Senate plan. That would be a card that they would get that would allow them to get a discount of some sort when they go to the pharmacy. In addition to that, those with low incomes would get a debit kind of card from which they could use to purchase their drugs. Beginning in 2006, the real Medicare drug benefit would kick in. And the House and Senate benefits look a little bit different, but essentially they each have a deductible, they each have a co-insured, they each have what's been called the hole in the donut, which is the gap in benefits, which kick in at different times in the House and Senate bill. And then they both have catastrophic protection for those with very, very high drug expenses. You know, how people fare under each proposal, depends upon what their individual circumstances are. Under both the House and Senate bill, the drug benefit would be delivered by private plans. Either plans that provide just a drug benefit, to those who choose to stay in traditional Medicare, or to an integrated plan, like a PPO, or an HMO.

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LARRY LEVITT: So, just to recap, seniors would pay an upfront deductible -

TRICIA NEUMAN: They would pay a deductible up front, they would pay a co-insurance up to a specified amount, and in the House bill they would pay a twenty percent co-insurance and in the Senate bill they would pay a fifty percent co-insurance. Then they would reach a benefit limit, which is what everybody is calling the hole in the donut, where they pay the full freight and then after they reach a certain amount they would get catastrophic assistance. And of course everybody would pay a premium and the premium is estimated to be thirty-five dollars a month in 2006. But that is just an estimate and it would depend upon the plan they select.

LARRY LEVITT: And obviously this drug benefit is just one of the many issues the conference committee is facing. Could you run through what they've agreed to and -

TRICIA NEUMAN: Yeah, I mean finally enough, while there are differences in the benefits, the benefit itself hasn't gotten that much attention, at least so far in the news reports about what's been going on in the conference. There are some areas of apparent agreement and there are some areas that seem to be very much on the table. There seems to be agreement about the discount card and the subsidy for the low-income population. There seems to be some interest in providing coverage to people who are eligible for Medicare and

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Medicaid under Medicare and that was a very contentious issue. The Senate would have kept so called dual eligibles in Medicaid and the House seems to have prevailed and now they would be entitled to the same drug benefits as others. That seems to be a point of agreement. But there are still several tough issues to work through. Probably one of the biggest is how much competition there should be involving traditional Medicare. There's a provision that the, they call it the feed style competition plan -

LARRY LEVITT: That's the federal employees program?

TRICIA NEUMAN: The Federal employee health benefit program, but that's competition between traditional Medicare and private plans and that would begin in 2010. That's a big issue and I guess that's on the table for this Friday. Other issues include whether or not there would be a fall back plan. Which means if these private plans don't come to provide a drug benefit, who will be there and will there be guarantees for people all across the country? The Senate has a different way of doing this than the House, and I think that will be a big issue. The magnitude of the low-income subsidies is sure to be an important and costly issue. Recently retiree health benefits have become a very important issue for the conferees. There's concern that employers will accelerate the process of pulling out and terminate benefits for retirees. That's clearly a big concern.

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LARRY LEVITT: And many employers have been pulling back on retiree coverage already.

TRICIA NEUMAN: Already, absolutely. You know there are a host of other issues. Should there be income related benefits? Income related premiums? And you know we could probably go on forever on the differences.

LARRY LEVITT: The bills are several hundred pages long.

TRICIA NEUMAN: That's exactly right.

LARRY LEVITT: Marilyn, as Tricia described the benefit with the deductible and the hole in the donut, this is not the kind of benefit that most working age people would expect to receive. Can you give us a sense of how much seniors would end up paying, how much coverage they would end up getting under this benefit?

MARILYN MOON: Well, I think Tricia did a pretty good job of indicating how complicated it is. And it depends a great deal on where you are, in terms of how much spending you're going to be doing and whether or not the House or Senate prevails. One way to think about it is that four hundred billion dollars sounds like a lot of money, but over the next ten years, this population will spend about one point eight trillion dollars on prescription drugs. So that makes this less than a quarter of the cost that people face. Now someone who chooses to buy this benefit, because they'll pay a premium,

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will get better coverage than one quarter of their benefits covered for the most part. But the interesting way that it works is that people initially will get a pretty good benefit if they spend; let's say a thousand or two thousand dollars on drugs. And then it deteriorates, particularly in the House plan, so that people who have what we think of as chronic conditions, where they may be taking three or four drugs every day for anti-cholesterol drugs, or the anti-ulcer drugs that you see advertised, that will put them in the donut hole and they may get as little as a third of their costs paid for when you average it all out. So it's going to vary a lot and it's not going to be what I think a lot of seniors think they're going to get. That is, they're going to stand in line at the drug store and pay the same ten dollar co-pay I pay. It won't be that way at all.

LARRY LEVITT: And it's a voluntary benefit. Seniors don't have to sign up, but they do have to pay a premium and in fact there's a penalty if they don't sign up initially. What's your sense of how seniors are going to end reacting to this?

MARILYN MOON: Well I think seniors are so hungry for prescription drug benefits that there actually will be a lot of enrollment, especially since the idea is that if you don't sign up initially you could face very large penalties over time. And that's going to scare a lot of people into buying the benefit. It's also going to mean though there are going to be

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a lot of disappointed people who along October or November are standing in line at the drug store and find out for example, that they are paying the full price and the government is not paying anything, or their plan is not paying anything.

LARRY LEVITT: Right. Joe Antos, as Tricia talked about, the drug benefit itself is one of the least controversial issues before the Congressional Conference Committee. Among the more controversial issues that have tripped up the conference committee are the notion that Medicare should move towards more market competition, greater use of private plans. What's your stance of how this privatization, if that's the right word, would work and what's the case for doing that?

JOE ANTOS: That's right, that is probably the single biggest political issue, I think substantively it's not so clear that it's the big issue that it appears to be from a political standpoint. Certainly the objective of introducing a strong competitive element in Medicare is two fold. One is to hope that market forces would cause the cost of the Medicare program to grow less quickly than it would otherwise. Not, not reduce, grow less quickly. And then the other objective is to give beneficiaries more of a choice. As Tricia and Marilyn both pointed out, the structure of the drug benefit in particular is mighty peculiar. And there are plenty of very sensible people who would like something else. So I think the

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objective there is to, at least ideally, give them an option that would be more suitable to their tastes and their needs.

LARRY LEVITT: And the House and Senate have taken the different approach on this market competition, which is part of what the conference committee is trying to reconcile. What are the two different approaches here?

JOE ANTOS: Well, as Tricia had mentioned, the single big difference, which is the so-called premium support. I think that's the term I tend to use. As Tricia said, it's the federal employees health benefits' style program. It really isn't the federal employee's health benefits program however; we have to be careful about this. The basic idea is that starting in 2010, in counties or in market areas, however defined, where there is significant enrollment in private plans, so in other words we've already started the process of having people potentially enroll in PPOs or other kinds of private plans, starting in 2006. So by 2010, if there's enough enrollment, then under the House bill, things change dramatically. And the bids that the private plans would place before the government would go head to head against the Medicare costs of the traditional Medicare program. And that would influence what beneficiaries would pay in their premiums, if they selected a private plan or the traditional program.

LARRY LEVITT: The traditional program would really be one of several choices available to beneficiaries and how much

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they would pay would depend on how much each of those plans, or choices, cost, right?

JOE ANTOS: That's right. Now, the House bill attempts to moderate the effects of this, but it's again, politically it's a big, big change from what we've ever seen in the program. The moderation has to do with phasing in this, this sort of differential in premiums if there is one, over a five-year period and as I say, restricting this to market areas where there is fairly substantial enrollment already in these alternatives to the traditional Medicare program.

LARRY LEVITT: We've got our first caller on the line. Let's move on to a caller from Washington. Caller, go ahead.

CALLER: Hi. I have been, I'm a graduate student and I've been following the issues surrounding adding a prescription drug benefit to the Medicare program. And I notice some of the concerns have been raised regarding adding such coverage and what would then be the effect for employers and whether or not they would reduce benefits for retirees. And I guess what I'd like to know is, why is this an issue with passing a drug bill? Particularly considering that employers seem to already be dropping or reducing such coverage. So I'd appreciate any comments that you can add to that.

LARRY LEVITT: Thanks for your question. Tricia, maybe you could start by describing you know, where we stand now with retiree coverage and what's been happening there.

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TRICIA NEUMAN: It's a great question. And one of the reasons this is such a big issue is that employer sponsored retiree health benefits is a terrific source of drug coverage for people on Medicare today. Those who are lucky enough to have an employer provide drug benefits, get the best drug coverage that's out there. So, those that have it are genuinely concerned about losing such good coverage because they don't know what they'll get once they give up the good benefits that they have. The caller is absolutely right, there's a lot of evidence to show that employers have been pulling back on retiree health benefits. And many employers have terminated benefits for their future workers. I think they're trying to hold the line on their current retirees but there's, our own survey's have shown that employers have said they are likely, many employers are likely to terminate benefits for their retirees in the future. So, this trend is already happening and I think what you see on Capital Hill is the desire to slow the trend or at least not to accelerate it. And so the conferees are trying to look at options that would try to keep employers in the game for as long as possible. And that's really what this is all about.

LARRY LEVITT: And Joe, there are estimates out there for how many employers might drop coverage if a drug benefit like has been proposed were passed. Can you give a sense as to what those estimates are?

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JOE ANTOS: They're all over the mat. Thankfully, keep the rest of us employed for a long time arguing about this. This is a program that is brand new and so it's reasonable that there would be a lot of speculation as opposed to real facts on here. The Congressional Budget Office says that about a third of Medicare beneficiaries, who have retiree coverage for prescription drugs, would lose it. That's about four million people. That's quite a few people. The Employee Benefits Research Institute, based on a survey that wasn't Medicare specific, says well no, it's not going to be that bad. They're thinking that it will be more like nine percent. I have to say that as a graduate of the Congressional Budget Office and as a natural pessimist when it comes to the effects of government policy, I would not look for the optimistic results.

LARRY LEVITT: Marilyn, do you?

MARILYN MOON: I disagree a little bit on that. Both of these bills would provide subsidies to employers to stay in the game. And if an employer is kind of on the tip-point there, they're spending a lot on prescription drugs, and they get a subsidy, they may stay in the game a little longer than they otherwise would have. I think we really don't know what's going to happen. Particularly since the generosity of this benefit is nothing to crow a lot about. I think there are a number of employers who will stick it out for a while even if they were otherwise planning to cut back. So, it's going to be

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very hard to know because we're never going to know if this bill passes, what would have been without the bill. So there's going to be a lot of second guessing even after the fact.

JOE ANTOS: I would just add to that, that I think these estimates are really talking about what happens at the end of ten years. So, I agree with Marilyn, I think we all agree, that the first year, a wise employer will wait and see. And then decide what to do. I think everyone should wait and see because it's pretty mysterious right now how this benefit is really going to act and many employers may find that whatever the subsidy turns out to be, is enough to keep them interested. But of course there is the longer term risk that they face of unpredictably high employee and retiree health costs. That's what they're going to factor in to their decision.

LARRY LEVITT: And already retiree health costs have been going up quite fast, with employers covering the cost of prescription drugs rising at fifteen, twenty percent a year.

JOE ANTOS: Yes.

LARRY LEVITT: We have another caller on the line, from New York. Caller, go ahead.

CALLER: Yes, thank you. What is to prevent an employer who is paying retirement benefits or, and a union who is paying retirement benefits from picking up the premiums for a retired worker? Picking up the Medicare premiums for a drug

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benefit? Either paying it directly or paying back the retiree for the premiums that they paid out of pocket?

LARRY LEVITT: Yeah, I mean under the current Medicare program it's not uncommon for an employer to wrap around Medicare to fill in the holes in the existing program or maybe pay to have a supplemental coverage for retirees. How would the current bill-?

TRICIA NEUMAN: You know, I think as Joe was saying I think employers are going to take a look at these bills and sort of calculate what it is they might get in terms of subsidies and support to maintain their businesses to their benefits before they decide whether they'll want to continue to provide primary drug coverage or wrap around the Medicare benefits. But as the caller suggested, some may choose to pay for the part the drug premium and that's also an option that would be permitted under the House or Senate bill.

LARRY LEVITT: Let's move on to, we've got some questions from e-mails as well. We have one from a reporter in Washington asking about income relating which is one of the other, one of the many controversial issues before the conference committee now. Let me read the e-mail: "the House bill, as you all know, would link catastrophic health care coverage to beneficiaries' income. There is now considerable talk in the Medicare conference about making the same sort of income link for part B premiums and maybe even to the drug

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benefit itself. Wealthier people would pay more before they could get the benefit. Are these income relating provisions good policy? Are they workable? Would they mean the beginning of the end of Medicare as an entitlement for all?" Marilyn, maybe I would start with you to take a crack.

MARILYN MOON: Well the question really does raise all the issues that are on the table about this. The first thing is that there are a lot of people who are sympathetic to the notion of income relating, who will say, why should Ross Perot get full benefits and subsidies from the Medicare program? The basic problem there is there aren't enough Ross Perot's out there. And if you really want to get a lot of people paying more, you have to go very far down the income scale before that happens. So there's a lot of practicality about that. The basic question of is sixty thousand dollars as the cut off, for example, is that high income? Some people would say yes, if we're talking about the income tax, people will say no, no, no, that's a low-middle income, and high income may be more three or four hundred thousand dollars a year. So there are practical issues. I think the philosophical question is the toughest one to deal with. There are a lot of people who split on this because they're going to argue that we already have a situation in which higher income people pay more for the Medicare program as workers when they're paying in through the payroll tax.

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LARRY LEVITT: Which is a percentage of wages. So higher wage people pay more.

MARILYN MOON: That's right. And there's no limit on that. So, someone who makes four or five million dollars a year will be paying taxes on every dollar of wages for the payroll tax. Also, the income tax, which is paid by high income seniors and persons with disabilities who are on Medicare helps to fund part B of the program and will fund the drug benefit as well. So we already are there in a sense. The question is do you add premiums on top of that that are higher for high income individuals. I think most people who worry about the program and support for the program would be opposed to having the benefits changed by income but they are going to split on whether or not they think that there should be some income relating on the premium. And it's an interesting kind of split, because it really does fall in various different ways among people that you might think would be one side or the other and don't turn out to be.

LARRY LEVITT: Joe, do you think there are either philosophical or practical differences between charging higher income people a bigger premium versus giving them lower benefits?

JOE ANTOS: There are huge practical implications. Can you imagine having the kind of computer system that will instantly communicate information sufficient so that we know

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that you know Marilyn is eligible for the, sort of the first level cut off on the catastrophic but I am not eligible you know for a couple steps up? That will be tough to explain to people who are probably still have some influence at least in terms of voting. There's another irony in this though that I find interesting. The, both houses of Congress have accepted a kind of income relationship here by saying that lower income people should get an additional subsidy for the prescription drugs. I think, again, it's a fine policy principle. So, what they're arguing about isn't the principle, it's how you do it.

MARILYN MOON: Well I think though it's a little more than that because I think the concern is that if you limit the benefits or even the, raise the premiums for higher income individuals, you lose some support at the higher income levels. And that does make a difference in extra protections for low income beneficiaries.

LARRY LEVITT: Then there's a history of right of extra protections through, for example, Medicaid, which provides additional help for low-income people.

JOE ANTOS: That's right. So, this is of course, as usual, a very clear political issue and we're confident that by Friday they'll have it resolved.

LARRY LEVITT: Yes, I'm pretty sure they're confident. We've got another caller on the line from Washington. Caller, go ahead.

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CALLER: Hi, I just have a question about the competitive bidding system. Under the House bill I know it creates a competitive bidding system whereas under the Senate bill, it does not. Can you just speak about the different ramifications, specifically thinking under the House bill if there is a system that's created, the potential affect it will have on Medicare part B premiums?

LARRY LEVITT: Joe, do you want to start and sort of just describe how this would work? And in particular how it would affect how much people would end up paying.

JOE ANTOS: Well of course we can only speculate but at least in the first few years, the idea would be that these private plans would submit their bids. Think of the bid as the full cost of providing Medicare covered services. It's more complicated than that, but think of it that way. And then the comparison is with Medicare, the full cost of the traditional program providing those services. A formula would be invoked and essentially what would happen is that if these private plans came in less expensive than the Medicare program, than the traditional program, then that would give them an advantage over Medicare and in essence, the portion of the Medicare cost that was over and above the weighted average of all the bids, including the Medicare program, would be apportioned out in the form of higher premiums. Now, there's some real question about how big those premiums could get. There's some real concerns.

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I haven't seen any estimates so I don't dare speculate on numbers. But the issue has to do with; will the private plans attract the healthier beneficiaries? Will the traditional program retain the sicker, more expensive beneficiaries? And will that cause a wedge that is unrelated to the efficiency, let's call it, of the plans?

LARRY LEVITT: So in other words, if traditional Medicare got sicker beneficiaries it would raise up cost and force it to charge a higher premium and just the opposite maybe for -

JOE ANTOS: That's right. And although the House bill does have various risk adjustments and mechanisms, we know that those aren't perfect and never will be. And so that leaves this, this question and this concern that the traditional Medicare program will become the warehouse for the sick. I, my personal view is, that the private plans will be shadow pricing the traditional program-

LARRY LEVITT: Pricing just below the traditional program?

JOE ANTOS: Yeah, they'll be sort of competitive but they don't have to be too competitive. And so another possibility, which I tend to believe a little bit more, is that we won't see, at least immediately, the huge reductions that some politicians hope for in premiums and cost. But we'll kind of see the program continuing on as more or less as it has and

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at least initially that's not such a bad outcome.

LARRY LEVITT: So nothing too bad, nothing too good? Tricia, the Medicare program has had some experience with private plans already with the Medicare Plus Choice Program, and the Medicare Risk Program before that. What, does that experience tell us anything about what might happen here?

TRICIA NEUMAN: Well, what I was going to say is just with the retiree health issue, there's a great deal of uncertainty as to how all of this will play out. And you're referring to, I think, to the Medicare Plus Choice experience where there was a great deal of hope in 1997 when it was enacted, that the number of people who would sign up for plans, the number of plans that would be available would continue to climb, and they did for a short period of time until payment from the government for these plans were not equal to the expectations of the plans and the plans started to pull out and their momentum started to decline. And so I think that raises the question of how will all this work in the future, particularly as the government starts to stare down major deficits and could turn to Medicare in the future as it has in the past to sort of help balance the budget, which may be an unfortunate reality that seems to occur. But getting back specifically to the twenty-ten question, and the role of competition, I think it's just hard to predict what premiums will look like, how much higher premiums under traditional

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Medicare could be when compared to private plans, how much variation there'll be within regions or in parts of the country. So you could have traditional Medicare having a premium of some amount in Florida but a completely different amount in northern California.

LARRY LEVITT: and that's that thirty-five dollar average monthly premium is a national average but it could vary from community to community.

TRICIA NEUMAN: It's a national average. Within community and from community to community. And I think it's unclear how the public will react to so much variation within the Medicare program.

LARRY LEVITT: Well let's move on. Not all the e-mails we've been getting have been fond of the private competition approach to controlling cost of Medicare. And let me read you a couple on controlling the price of drugs. One from a doctor: "We don't need to import drugs", referring to I think the reimportation debate, reimporting drugs from Canada, "we need to import drug prices. Why don't we use proven mechanisms such as bulk purchasing and negotiated prices? We have price controls in the Medicare program for physicians, hospitals, laboratories, why should the pharmaceutical industry be exempt?" A similar e-mail from Texas: "Instead of just adding a prescription drug benefit to Medicare, why is it not better for the U.S., for Congress and for the President to regulate

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the price of drugs so that they're more affordable for everyone including tax payers?" Marilyn, maybe talk a little bit about how Medicare has paid for other benefits, for doctors, for hospitals, and does that have some precedent for what we should be thinking about for drugs?

MARILYN MOON: Well the person who sent in the question is quite right. Medicare does a very direct job, for the most part, in setting the payments to physicians, to hospitals, and to other providers of services under the Medicare program. One of the advantages of that is that you have a lot more direct control; you can use the market power of the federal government as essentially the big kahuna of purchasing if you want to think of it that way. And the other advantage that I see is that when things get out of line, people squawk pretty loudly, get the members of Congress upset and things do come back into line. Now it's not a very smooth process, it's a pretty messy process and it leads to problems in some cases and inequities. So it's not, certainly, a panacea. But I do think it's interesting that we have put drugs into this box to say they're sacred while everything else is not. The drug companies have done a very good job of convincing people that research and development will go away and there will be no new improvements. I think it's interesting that the surgical changes that have occurred in the last fifteen years that go on in the large part for older Americans in areas like for heart disease, for hip

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replacement, for cataract surgery, all came about in a very price controlled system. So it's not by any means an indication that having government controls will eliminate research and development in drugs. But there are good arguments on both sides I should say, but my heart is a little bit more on the why not go the direct route, especially if compared to talking about importing from Canada.

LARRY LEVITT: Just in terms of Medicare's experience on cost, Medicare having regulated the price of, or set the price of hospitals and doctor services, how has Medicare's experience compared to the private sector?

MARILYN MOON: Medicare has actually done a better job than the private sector if you look at the rate of growth on a per capita basis, over a long period of time. There are ups and downs, some years it's a little bit ahead, some years it's a little bit below the prices in the private sector. But Medicare has done a pretty good job of tracking what goes on in the private sector. And as I say, adjusting when things get out of line. So, my sense is that this is not by any means been a failure as a program.

LARRY LEVITT: Joe, even aside from the merits, which you're welcome to address, what are the prospects for these kinds of price controls being enacted in this Congress?

JOE ANTOS: Well, let me first say, it's really refreshing to hear from a doctor who actually likes the fees he

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gets from the Medicare program. Let's sign him up. The prospects, I want to go back to the merits, but on the prospects, you know it's very tough to say. There was a lot of enthusiasm among Democrats and Republicans on the strong form of the importation bill, which leaving aside sort of the physical mechanism of where you get your drugs, that was really a vote in favor of let's have the government do something directly or almost directly to lower prices of drugs. So, politically, there is in the House, or at least there was in the House, considerable interest in doing something like that. On the other hand, it's also true that the concerns raised by the pharmaceutical industry about research and just the general concerns that other physicians and other providers have raised about you know the price system isn't working so well for them as far as they're concerned, I think probably dampens that enthusiasm. This is going to be a case of trade offs. It could very well be that the strong form of reimportation will pass in exchange for some greater elements of sort of competitive markets.

LARRY LEVITT: Reimportation, referring to the provision that would allow intermediaries or facilitators to bring drugs in from Canada at a lower price?

JOE ANTOS: Well, to bring drugs in from many countries. We shouldn't bad mouth the Canadians. I'd be delighted if I lived near the border to go to Toronto or some

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place and buy drugs for a Canadian drug store. I might not be so thrilled to buy drugs from other countries. Now, back on the sort of the merits of the issue, I just wanted to mention one other observation about the effectiveness of the Medicare price control system as opposed to other approaches. The other comparison, and I think maybe the better comparison, is with the federal employees health benefits program or CALPERS. CALPERS is the California Public Employees Retirement System, thank you. These are two big public sort of government run at different levels of government, government run health programs. So they have a lot in common with what we might imagine Medicare is or could be. And in the case of both of those programs, you see that they have done at least as well, if not better, again it depends on how you measure it, and what the (unintelligible) are, but they've done as well or maybe a little better in dealing with the cost problems as Medicare has. And I think what that says is, something that is regrettably almost always true, a new idea might be a better idea in some regards, but it isn't always going to be, you know, uniformly terrific. And in the case of controlling costs, I think, the average economist would argue that you can't really beat the market over the long run. Probably because if you could beat the market over the long run, with price controls, you'd be doing things that politically would be very difficult and I think we've seen Congress blink many

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times.

LARRY LEVITT: Let's move to another e-mail and switch gears a little bit. We've been talking a lot about seniors and seniors getting a drug benefit, but a lot of people on Medicare are under sixty-five and disabled, not necessarily seniors. And this writer from Arkansas writes: "All of the discussion I've heard today is centered around making prescription drugs a Medicare benefit for seniors, but I've not heard any mention of what is planned for those who are on Medicare because they are disabled. So what's the plan?" And Tricia, maybe you can describe both sort of what the experience of the disabled beneficiaries are on Medicare and how this bill would affect them versus seniors.

TRICIA NEUMAN: First let me say how glad I am to have someone reprimand all of us for talking too much about seniors and not talking more about the six million people who are on Medicare who are under sixty-five and disabled. All of whom would qualify under these proposals for the Medicare drug benefit. So while people use seniors as shorthand, I think it's important to note that people who are younger and on Medicare would also get these benefits. And they would essentially be treated as all other Medicare beneficiaries under the House and Senate plans. You know this is a population that's particularly important to take care of. The many people with disabilities use more prescriptions on average

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than do seniors. They tend to have higher out of pocket expenses so if they're not fortunate enough to have Medicaid, if they have very low incomes which would help cover their drug costs, they could really be out of luck and (unintelligible) and not feeling because they don't have coverage. So, fortunately the House and Senate proposals haven't excluded this population and they stand to benefit just as seniors do.

LARRY LEVITT: Well let me remind people that this is the "Ask the Experts" on Kaidernetwork.org and you can e-mail in questions. We have no shortage of e-mails but feel free to keep e-mailing in your questions to ask@kaisernetwork.org or you can call and ask a question on the air at 888-KAISER-8 or 888-524-7378. While we're on the topic of the disabled, a lot of these disabled Medicare beneficiaries are what are known as dual eligibles. They're on both Medicare but because they have low incomes, they're on Medicaid as well. And that's been one of the many tough topics the conference committee has been addressing. We have an e-mail addressing this issue. "Regarding coverage of dual eligibles, under the new Medicare prescription drug plan. How do the panelists view the present cons of covering or not covering dual eligibles under the Medicare drug proposal?" Marilyn, maybe you could describe what the issue is here, what the conference committee members are struggling with.

MARILYN MOON: Well, the issue has largely been one of

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cost. When you're going to provide very comprehensive benefits as usually is done for low income individuals under both of these proposals or the attempt to do so. Then the costs get to be very high very fast because there are a large number of low income beneficiaries. So both the Senate and the House looked for ways to hold down the cost of those low income protections. The Senate chose to do it by saying this should be the role of the Medicaid program, which is jointly funded by the states and the federal government. And therefore people who are dually eligible, get both, they should get their drug benefits through this program. Now, in every state in the United States, the Medicaid program does cover prescription drugs but not always comprehensively and often with great reluctance on the part of some of the policy makers in the states because of the cost are rising so rapidly. So, one issue is whether or not the very lowest of the low incomes, the poorest of the poor if you will, would continue to get high quality prescription drug coverage as compared to other people on Medicare. So that's one issue. The House chose to do this in a very different way. They leave that hole in the donut, that gap there for the low income individuals, which means that everyone is eligible but they don't get very good benefits. And so that's a particularly important issue there. But I think the other question comes back again to the philosophical issue of if everyone is eligible for Medicare who have paid in to the Social Security

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system and is eligible for some type of social security benefit which is how you get on Medicare, then why say just because you're low income, you're not going to get a Medicare benefit? And people are afraid that we will see this schism get larger over time rather than smaller. And I think they're very afraid of having to endure even higher costs over time.

LARRY LEVITT: Yeah and in some sense that's the nub of the issue here is money for states. Joe, give us a sense of how much money are we talking about here? How much, if the federal government took over the cost of these dual eligibles, how much, or the drug costs, how much would states save? How much are states spending on this benefit?

JOE ANTOS: You know it's not very clear because even in the House bill, the states have a requirement to continue to support their dual eligibles, you know when the coverage weakens or disappears. The cost estimate that I remember, and I hope someone remembers this better than I do, is probably some where on the order of forty billion dollars over ten years. It's very interesting, I think that if all we cared about was money, I think that the House bill and the Senate bill, this is leaving aside whether the benefits are adequate or any political principles, but money, I think there isn't much difference between the House and the Senate bill. All the Senate really does, by excluding dual eligibles from the Medicare drug benefit, is to amass some money that they then

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redistribute to the states in a different way. Now, fortunately for the conferees, it's much more complicated than that.

LARRY LEVITT: We have another caller from Kentucky. Caller, go ahead.

CALLER: I have a question. Just in reading over and looking at all the material on Medicare and listening to your program, I'm really more and more impressed with the complications of this bill. It's so complicated that it would be extremely hard for most seniors to be able to know what to do and so I'm wondering if there's any sense at all of just, well, I would say, putting this whole bill aside and trying again, particularly after the next election, the 2004 election? Thank you.

MARILYN MOON: I think that there's no doubt that this is a very complicated bill and I have great concerns that there has not been enough attention paid to helping beneficiaries wend their way through this process if it were to pass. If you're going to have choice among drug plans, you're going to have drug plans that vary in terms of the benefits they offer, how high the deductible is, how high the co-pays are, and what drugs are covered under what conditions. There may be differential co-pays for whether you get a generic drug versus brand name drugs, versus preferred brand name drugs. And for any of us that stood in line at CVS and wondered at the co-pay

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we pay and the pharmacist usually wonders too because it pops out of the computer and nobody knows exactly why, it's going to be that complicated or more for both persons with disabilities and seniors to figure this program out. The real question about delaying this, and I think the dilemma of that makes a lot of people pause who find a lot of flaws in this bill, that there's four hundred billion dollars out there, inadequate to solve the problem, but a lot of money and it's very hard to say, let's just give that up and hope next year it's still on the table considering the size of the deficits and the other demands on the federal government at this point in time.

LARRY LEVITT: Tricia, what's your sense and the foundation has done focus groups and surveys of seniors, when you describe this benefit and this program to seniors, how do they react?

TRICIA NEUMAN: I think the potential for confusion is enormous and I think it starts in 2004, not 2006 if Congress enacts this Medicare endorsed discount drug card, I could see my family members getting their Medicare card and thinking they have a Medicare benefit and going to the pharmacy and expecting to pay ten dollars and instead paying ninety percent of what they would have paid. So I think confusion will begin pretty quickly. The focus groups that we have done show that seniors are paying a lot of attention, I'm sorry, seniors and people with disabilities are paying a lot of attention to this issue.

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And what they're going to do is sort of size it all up, when they go to the pharmacy. And they may not be paying much attention right now to the nuances of the House and the Senate proposals because it's awfully complicated for all of us, but they're going to start to really pay attention in 2006 when all these plans are providing the option to sign up and they've got to choose their plan, they've got to track their drug costs, understand when they're in which part of the benefit and whether they pay a co-insurance or whether they're in that so called donut hole and they're paying a premium but not getting a benefit. And I think they'll want answers and you know, one of the questions is will there be an independent place where they can go for answers on how their benefit works, what drugs are covered, what drugs should be covered? Because for them they want it to be user friendly. And really it should be user friendly.

LARRY LEVITT: Joe, I think a lot of people in Washington remember the catastrophic debate and seniors jumping on Chairman Rostenkowski's car. Is that something you think is likely to happen if this bill passes? Are seniors going to look at this and -

JOE ANTOS: His car is probably in the junkyard right now. I think there is little doubt that if the kinds of benefits that we've seen so far in the House and Senate bills were to pass, either one it really wouldn't make any

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difference, that there would be tremendous political pressure starting immediately. And probably being realized in terms of actual legislation in 2005 to do something about it. Now, you know, it's really hard to say how this is going to work out though, because there are provisions that say that the plans can, as long as they are actuarially equivalent to what's, you know this complicated structure that we've been talking about, that it's okay. And there's a debate on the Hill about whether it's really okay or not for a plan to deviate from that structure. But let's suppose that it really is okay. Then we're really lost because it's very possible that smart people in the you know, in the health insurance and health benefits business would say well this is crazy, I can't do this, I couldn't sell this product. They've already said that. So, given the money that we have to work with, what can I do? If we're fortunate, then maybe the options that are available to everybody will make more sense when we finally roll around to 2006. As far as information is concerned, I don't think enough attention has been placed in these bills to this question at all. To say in a stump speech that we're going to give information just like the federal employees health benefits program, but not to build it into the law, is a big, big mistake and you know, I think we can expect that the centers for Medicare and Medicaid services will do what they can. We hope that AARP and other senior's groups will get right on

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there and give people the kind of information that they'll need.

LARRY LEVITT: You mentioned, you know the bill to maybe change the terms of it being introduced next year or thereafter. One of the criticisms of this bill has been that this is an expensive entitlement that's just going to get more expensive over time and we're already dealing with a Medicare trust fund that's, some would say, in difficulty. We have an e-mail asking when will the Medicare trust fund actually hit zero unless benefits taxes change, do all analysts concur on this timing projection? Marilyn, you served as a trustee on the trust fund. Give us a sense of where does the trust fund stand and -

MARILYN MOON: Well the easy answer is no-one agrees on what will happen over time as I think we've all been saying all day today. I think the trust fund itself is in reasonable shape right now. And that's really not the issue that's driving this question. The real issue is whether as a society we're going to be willing to pay the money that's necessary to provide the kinds of benefits that people have come to expect and hope will happen in terms of improvement. The Medicare benefit program is pretty skimpy and not nearly as good as what most younger working families have. It's an extremely popular benefit and the answer for me is fairly simple, and that is, as taxpayers we're going to have to put a crow bar in our wallets

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if we want to maintain this program as the number of people in the program doubles.

LARRY LEVITT: So revenue is being the answer?

MARILYN MOON: I think more revenues are going to have to be part of the answer. We're going to keep plugging along trying to find ways to save costs but that's never going to solve the whole problem. And people have danced around this issue for a very long time but haven't been very honest about it. Medicare has never been well funded. It's been closer to bankruptcy many times than it is at the moment in terms of the trust fund. But the issue really is, as a society do we feel we have enough resources to pay for services in this way for a population that largely has not been served well by the private market?

LARRY LEVITT: We've also got a number of questions about raising the retirement age, raising the eligibility age for Medicare. Joe, how much, would that save a lot of money? Is that a good idea?

JOE ANTOS: Well, I think it's probably a good idea but it wouldn't save a lot of money. After all, the retirement age, and we're not talking about the disabled, the disabled, from the moment that they become eligible for Medicare, remain in Medicare throughout. So we're really talking about people who are turning sixty-five, not disabled. A very high proportion of them are quite healthy. Increasingly so. That's

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a good thing. If you say well okay, let's raise it to sixty-seven tomorrow, we won't save a lot of money. That doesn't mean we shouldn't do it. After all the normal age of retirement for social security purposes is working its way up to sixty-seven and it makes sense for those two programs to be somewhat in sync. And there are some arguments that one could make about what to do about the people who are nearing the age of Medicare eligibility, which you know, that's another complicated issue. But nonetheless, it won't save a lot of money. There are other things you could do to save some money. Certainly the idea of doing a better job of giving people more responsible choices, making them more aware of their costs, of the costs of health care, and giving them realistic choices. I think that's something that will be in our future, inevitably, or we'll have a truly broken program.

LARRY LEVITT: Is there anything in these bills that would move us in that direction?

JOE ANTOS: It depends on your taste. Perhaps I think that the competitive plan features will really only work if the competitive plans are there and I think there are major, major problems with the way that both the bills are structured as far as really seeing these plans come to the Medicare program and be able to get a toe-hold in the program, and also to be able to compete on a fair basis. I think that's very important.

TRICIA NEUMAN: I'd like to add that there are some

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things in the bill that actually go in the wrong direction, I believe. That these plans, the PPOs that would come into place right away in 2006, we're going to provide subsidies through the federal government to essentially coerce them to come into the market. So we're going to overpay these plans for a period of time and as we've seen with Medicare Plus Choice, it's very hard to stop overpaying them when everybody gets used to extra payments that sometimes get translated into higher benefits. So, we're going to be setting in place essentially, an unlevel playing field and yet somehow expecting competition is going to save the Medicare program. To me, that's just totally backwards in terms of what we ought to think about. I would also like to add on the age of eligibility, I think you could do that but you would have to do so many other things to protect those individuals that we haven't been willing to do. The private market for people buying insurance in their early sixties is very broken and to add another whole group of people to that without major change, would be a disaster. And so while I think you could raise the age of eligibility, I think it would be very poor policy because we would save only a little money and we'd create another big crisis of the uninsured.

LARRY LEVITT: Well we could talk about this all day I'm sure. And we've got dozens of calls and e-mails to demonstrate that, but we do need to wrap up in a few minutes.

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Let me ask you, I won't ask you, any of you to put a probability on whether we're going to have a bill this year or not. But there has been discussion of a "plan b" if a bill can't pass. Is there an incremental smaller scale program that might people? Whether that's helping low income, seniors and the disabled, getting discount cards out there to lower prices, allowing reimportation of lower priced drugs from Canada or other places potentially? I'd like each of your sense about whether than kind of "plan b" is something that would be helpful, what form might something like that take if Congress can't agree on a full scale program? And Marilyn, begin with you.

MARILYN MOON: "Plan b" is better than nothing because there are a lot of low-income individuals who really are suffering now, not getting the prescription drugs that they need. On the other hand, both parties and the President promised mainstream Medicare beneficiaries a prescription drug benefit and offering one to people who have very low incomes is not going to make that population happy. I think that's not going to satisfy the demand that's out there and the promises that people have been made.

LARRY LEVITT: Jim?

JIM ANTOS: I can't add to that other than to give you a probability. Being an old scorer I might as well. Not a real probability. I agree with Marilyn. I think it's going to

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be a comprehensive bill or nothing. And we'll know in the next month.

LARRY LEVITT: And Tricia?

TRICIA NEUMAN: Part of the problem with going with "plan b", is "plan b" can sound like a cheaper alternative but it could be quite expensive. Someone talked about a catastrophic benefit and a low income benefit, but that's really where much of the money is. So, it's not so easy to provide to certain groups that people perceive to be most vulnerable at a big discount. So I think that could be pretty hard to carve out. And there are political ramifications of not providing a benefit to everyone who needs it. So, I'm sort of in agreement with my colleagues here.

LARRY LEVITT: Well that's a nice agreement to end on. I'm not sure we've solved anything today, but hopefully helped educate some people about some of the complications and the details in these very complicated bills as I think everyone would also agree on. Certainly watch, thanks everyone for joining us, panelists, experts in particular, and the e-mailers and callers out there. And please join us in the future for more kaisernetwork.org "Ask the Experts" sessions. Thank you.

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