

CATO INSTITUTE

HILL BRIEFING

WHAT'S RIGHT AND WRONG ABOUT THE SENATE MEDICARE BILL?

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Moderator and Panelist:

Tom Miller, Director,  
Health Policy Studies, Cato Institute

With remarks by

Senator Don Nickles (R-OK)

Panelists:

Michael O'Grady, Senior Health Economist,

Joint Economic Committee; and

John Goodman, President,

National Center for Policy Analysis

608 Dirksen Senate Office Building

Washington, D.C.

P R O C E E D I N G S

MR. MILLER: Let me get a couple of clichés out of the way so I can get them out of my system before we get into the main part of our program.

"It's not over till it's over."

"It's not all about the children."

"When you're in a hole, stop digging."

"We're lost, but we're making good time."

"Don't fire until we've formed a circle."

"You just don't get it." And

"The money's gone,"

That's from It's a Wonderful Life, if you remember, with Jimmy Stewart.

Now we'll get down to the substance of today's briefing, about what are the prospects, the future or the past, for Medicare reform in the current action in both the House and the Senate? I believe Senator Don Nickles, who was a stalwart in the proceedings on this in the Finance Committee about a week ago, is on his way in here. And then we'll be going to our speakers. I'll be one of them. Also John Goodman from the National Center for Policy Analysis, and Michael O'Grady from the Joint Economic Committee.

A little overview of what I want to talk about is as billed: What's wrong with the Senate bill? And I may wander into some of the House legislation briefly. Some politics and policy lessons from what we've seen over the last month and perhaps some alternatives, if there are any remaining, to keep us from digging a deeper hole and maybe find a market ladder out of it.

What's right about the Senate Medicare bill? I'm thinking....I'm still thinking. I may have a few extra minutes. Well, as Dr. Evil says in one of the Austin Powers films: Throw me a frickin' bone.

So I'll at least come up with a couple of things. The transitional drug coverage. If you just stop there, it isn't too bad for the next two years. A discount card. Assistance to the low-income Medicare beneficiaries not eligible for Medicaid drug coverage. That does phase out, though, under most plans, in about June 2006. And maybe, if they do it right, the indexing, if you can sustain it, to not let what remains of the cost sharing get eroded by rapidly increasing spending on drugs. If you index it to the average per capita expenditures on covered drugs, as in

the Senate legislation, you might hold the line a little bit longer.

Well, what's wrong with what's in the Senate bill? You're just making a down payment. This is an entitlement. It's going to be around a long time. And it's going to grow. That's what the balloon notes are about, either with unfunded liabilities or other later expenses. We start at \$400 billion over eight years, because that's what is in the budget resolution. But as an old Paul Simon song of the seventies said, one man's ceiling is another man's floor. And I think we know who believes it's a ceiling and who believes it's a floor.

Most folks are treating this as a floor, to be increased later on. For calculations of the long-term unfunded liabilities, the one I've used tends to be the perpetual one by Jagadeesh Gokhale and other colleagues when they were working at the Treasury, which is \$36.6 trillion, in perpetuity, discounted for present value, for just Medicare alone.

I always like to say that, just by working on Medicare policy, I'm responsible for about 80-90 percent of the unfunded liability, so I want a little respect, as opposed to those other issues that don't even contribute to it at all. And that's without a drug benefit. Of course,

a different calculation might add another \$8 trillion to \$13 trillion.

Now, we've known this problem with the Federal Government, in terms of our method of accounting in budgeting, for some time. It doesn't always tell the tale correctly. A study of this once referred to the problem of "cash basis" accounting as leading to a misallocation of the national resources, jeopardizing sound programs and burdening future taxpayers. And that was by some independent public accountants and consultants who were very public spirited. They did this study and they said, "we've seen how a lack of accountability caused by inadequate information and the failure to account properly for the full cost of government programs can help produce a fiscal crisis."

Now, that publication was called "Sound Financial Reporting in the U.S. Government: A Prerequisite to Fiscal Responsibility." And you know, it takes one to know one. Do you know who put that out? Arthur Andersen & Company.

So a clean hands doctrine is what I remember learning about in law school, but that's a matter of equity.

Well, what's wrong with this fiscal meltdown that might be ahead? Obviously the usual problems in terms of

higher taxes, slower growth, and what it does to younger generations. It squeezes out other alternatives within the budget. Over time, because you can't pay for it, you get more hollow benefits. And that creates the backdoor pressures for price controls. We've seen them for physicians and hospitals; and welcome to the party, pharmaceutical drug makers. And of course there's a bigger role for government throughout the health care sector.

Is this pit, though, bottomless? Will we just kind of go on forever and ever? But until we know we're not going on forever, are we running out of time to roll back the demographic health spending clock before there is not enough time to recover in that regard? And do we end up with a Federal Government that pretty much looks like this, a check-cashing ATM machine; there is not room for anything else; it's just transfer payments under the entitlements; and we don't have much else to do in the Federal Government?

Now, that's not all bad, in some ways, but I think it could go over the cliff in that regard. And we're certainly getting to that level in terms of the budgetary numbers.

In the Senate and, to a lesser degree, in the House, Republicans have pretty much signed on to this,

while uttering a few plaintive cries along the way. It's kind of a game of follow-the-leader. And I thought Senator Gregg summed up the acumen and deep knowledge of the Senate Republicans in this regard the other day: "It's a very fluid situation on the substance side of this because no one understands what the heck this bill says or will do."

That's after being briefed on it by CMS head Tom Scully and members of the staff of the Finance Committee.

That is about where the Republicans are marching in lockstep. But just when these lemmings thought it was safe to go back in the water, Bruce, the senior shark, got his AARP card. It's been a while since 1975. You know, he's kind of a gray shark rather than a white shark. He is there to devour, or at least take a big bite out of, the younger workers' paychecks and their savings. And as Brody said to Quentin in the Jaws movie: "You're gonna' need a bigger boat."

So, what's wrong with the Senate legislation? And I'll be a little bit more substantive and serious now. A fundamental problem is the failure to target drug benefits where they're needed. And most of you by this time know the basic details of the Senate legislation. It could get tweaked along the way or in the House or in conference.

But basically you know about what this is going to look like. Which is to make sure that there's not a big deductible at the front, in those early-dollar and high calorie sweeteners. Because everybody must get a benefit. They have to kind of touch it, squeeze it, and smell it. As Ross Perot would say, you know, run it through their intestines to know that they got something in return. They don't want real insurance. They want to get a guaranteed benefit.

The Senate does it at a 50-percent match, up to a higher level (since they found more money) to \$4,500 for spending. And then we have the shrinking donut hole -- it used to be bigger -- where you're not covered for anything, even though your expenses are actually more serious and you probably need the help more, but you have to wait until you can go later.

Then you get to the catastrophic coverage, which the Senate does it as 90 percent catastrophic coverage. And that starts, at the Senate level, at \$5,800. There's a different level in annual spending from where it kicks in in the House, but basically that's the structure. It's not much of something, but it is something for everyone, which is the political equation.

What is ahead, is that there is going to be some sticker shock in a couple of years, when folks calculate what they're spending on a premium and what their out-of-pocket costs are before they feel like they're net winners. Even though, if you thought of it in an insurance sense, there would be a way in which you had protection regardless of what you received in benefits. So there could be some buyer's remorse ahead when we actually look at what this is delivering and what people had expected -- a much more generous benefit -- than what turned out to be the case.

What's wrong with the cost sharing in the Senate? Well, what we're going to have is a fight over the next couple of years to fill the donut hole. And there will be all kinds of tough votes to say, well, can't you be a little more generous? So we've got kind of the two parties over here. We've got the Republican Party with their nice donut hole, and the Democrats are saying, we can put jelly in this donut and fill it all the way up, and isn't it yummy? Wouldn't you like to have this donut rather than this other kind of not-quite-filling donut in this regard? It's another version of minimum wage politics replayed a step at a time in terms of Medicare drug benefits.

Now, the House does try to do some means testing. They put the means testing, though, at the back end, at the catastrophic level, rather than at the front end, at the deductible. I could make an allusion to Republicans not knowing the back end from the front end, but I think I'll leave that out in this particular company.

Well, what's wrong with the crowd out? The accelerating erosion -- it's already going on with employer-sponsored drug coverage. But there is a CBO calculation, and a slightly lesser one for the House bill, that as much as 37 percent of the existing employer drug benefits would be lost or switched over to the standard, stand-alone coverage, depending upon how it gets delivered onto the new and improved Medicare drug benefit. And there will be some shifting of cost to the taxpayer. It will be a calculation, but some of the investment analysts have figured out that a couple of the big auto companies might say, hmmm, a good way to unload that headache, compared to other things.

There are some subsidies, though, to try to keep employers in the game, or partly dependent. And at least the calculation, I think from the Senate side, is about a 64 percent subsidy. That's if you do the standard coverage

and jump through the hoops to do it a certain particular way.

Now, the beneficiaries also who don't sign up initially, you've got a little bit of a perverse incentive, because they get to come into it if the employer says it's time to boot them out. So those employers don't even have to drop the coverage explicitly. If they just scale it back so it's less than the standard Part D coverage, all of a sudden it's a new entry into what was supposed to be a one-time entry for the drug benefits for employees who were previously getting drug coverage. So you could just, in effect, get cheaper on your drug coverage and move the bodies over there.

Now, what's wrong with competition that I've called "Market-based In Name Only" under this bill? Well, the entry of the new plans, particularly in the regional or national PPOs, is going to be limited. It's the lowest three bidders. So it's bidding to actually play as opposed to determine how much to pay. And that may mean that some of the big boys, if the deals are just right, will be coaxed in for a little period of time -- if they feel they can cover all their risks in every possible way and have some other subsidies going there.

This is not the original version of competitive bidding -- certainly on the Senate side; it's a little closer on the House -- that was proposed in the Bipartisan Commission in 1998 and 1999. Because this is kind of a one-way linkage. There is a ceiling set in most of the ways it's designed for the payments in terms of what the private plans get. And that ceiling is the fee-for-service level. But there is not the two-way street, where the fee-for-service program has to respond to what the bids are and what the levels are from private plans.

Now, the House would get to this eventually, and I'll talk about that later. Still, it's kind of a one-way type of set up.

And of course there are the risk corridors, because we know that the only parties who are more risk averse than Medicare seniors are private insurance companies. They're not there to take risks. They have to have the taxpayers take care of the worries. This is for the first two years in the Senate, but I wouldn't be sure that that wouldn't stay longer. That's how the PPO demonstration has been done. It provides guarantees both on the profit and the loss side in terms of limits.

I'm exaggerating a little bit but, in a sense, if you look at the way the numbers work, you're paid more to

be less efficient as a private PPO insurer, and then you have to give some money back if you turn out to be more efficient, but you can't make too much of a profit.

What a country!

What's wrong with competition, again, that's market based in name only? Well, there are other limits on it. You can't compete too much. The Secretary of HHS, under the Senate bill, can exclude plans that are believed to attract a healthier population. Even though these things are going to be mostly risk adjusted to handle all kind of variation on that front, this looks like a dagger at the heart of what might potentially be another effort to do MSA-like plans for Medicare beneficiaries. And you saw that one killed right off the bat.

As I said, the competitive bidding should be used in a better way, which is to determine the subsidy levels from the taxpayers. Then let the plans charge whatever they want, or they could be held to their bids, some higher, some lower, but it wouldn't determine who gets to get on the field and actually offer a plan. You might have to charge more for it, but we first would determine what the subsidy is through the competitive bidding, and then the rest is in effect a market determination on the margin.

Remember that market reform of this nature is coming on the heels of what happened with Medicare Plus Choice. That has already given market reform a pretty bad name in terms of what happened there. We can't afford another disappointing failure like the M+C program, and we well could be going back in that direction again.

Let's go to the authority on this -- Ted Kennedy, who has been straightforward and transparent and who has laid it all out there for folks to know. He has said about this legislation: It's pretty good and he supports it. On the other hand, he said, "In fact, if you think that Medicare should be privatized, then you should oppose this bill."

I think that's a pretty good analysis. We're thinking of bringing him on as an adjunct scholar, to at least give us some "neutral" analysis of the way in which these bills are actually being crafted. He's got the experience, and now he's just talking straight.

What's wrong with the regulatory overload in micromanagement in the Senate bill? Well, you can count the pages. That's one way to do it. Or the different silos and the separate payments that are still going on. We've got now Medicare Part D. I thought that one bill was talking about Part E. They must have been talking to Vanna

about buying another vowel. I think we can get the whole alphabet by the time we're through reforming the program.

Data collection, of course, will be intense, to get all the drug prices lined up, to know that you've got them all figured out, and then get them lower. So you get a bigger version of what is the current unsustainable traditional Medicare program. Which means less innovation, lower quality, and less flexibility.

We kind of go in two directions at once, and we do this every time with programs. First you press your foot down on that accelerator, and it's great and you're cruising along. Then you say, oh, my gosh, we've got to stop. And you slam on the brakes in a very crude way. And guess who goes through the windshield? The providers, the hospitals, and ultimately the beneficiaries.

What we need is something that can modulate this better; in effect, a market-based transmission. So you can change gears a little bit more gradually. And that's the idea of having private plans, to give you a broader variety of options.

On the regulatory overload and micromanagement ahead for the would-be stand-alone private drug plans, there has been analysis on this that indicates, basically, they're pretty much rigged to fall back. It's never Daylight

Savings Time where it goes forward; it always falls back, it seems like, to the single price-taking government subcontractor operating as the fallback plan administrator. We're unlikely to find a lot of risk bearing, but rather a lot of disincentives for private players to play in this unusual market for, in effect, stand-alone drug coverage.

The PBMs do a good job in the private sector, but you have to remember, at the end of the day, they're essentially taking and following orders. It depends how tough the employer wants them to be in terms of the coverage. But in this type of environment, they are going to be price-takers primarily for CMS, or whatever new and improved regulatory structure there is. And don't expect them to be really breaking your backs to do much more than get some uniform prices and get their little extra marginal payment. It's great thru-put. You make a profit and you handle a lot of volume. It's like the old Blue Cross/Blue Shield Medicare intermediaries, which didn't find anything out of much value, but they got paid for pretending to while they pushed paper through the reimbursement system.

And all of this sets up the structure where price controls on drugs become more inevitable and much sooner. And you also have much more regulatory complexity. It's inevitable because most of the members on the Hill don't

trust the private market to really do it. So they have just got to get back in there and make sure that it will turn out all right.

That's inspires another one of the political dodges. We think that if we just draw another regulatory box or carve out another structure - with a new and improved regulator or administrator, we could escape politics. But you've still got a defined benefit. You've still got 40 million beneficiaries. You've got every interest group feeding at the table. It's still politics. It just moved to another side of the street.

I know I'm getting out of my cultural era here, but I've described it as the old rock band the Who, which said in the rock opera Tommy - "Meet the New Boss, Same as the Old Boss." If only we also said, "we won't be fooled again."

Well, what do seniors really want? It's pretty clear that they want more. If you're going to put money on the table -- you remember the Budweiser ad -- put the money in the bag, stick them up. Who wants to leave crumbs around?

On the other hand, what they primarily want is not really this complex, convoluted setup of drug insurance; they want lower drug prices -- that's pretty

much the message that came across at yesterday's Kaiser Family Foundation briefing on public opinion -- and discounts. No one wants to pay retail anymore. And they want drug "assurance," not drug insurance. That may not necessarily be the enlightened view, but that's kind of the bottom line. And we may be talking past them with what we're creating right now -- as opposed to doing the simple thing, which is get the discount card, throw a little money around and go home, and not have this big superstructure.

Now, incumbents can run from this. And they're going to run next fall and they're going to win, but they can't hide, because the costs will come home and the results will come back. And so there is going to be an "après moi le deluge" moment down the road, or perhaps sooner.

Now, here are some alternatives. Because I'm not just complaining and going home as a sorehead, right? I don't have anything to come up with as a simple solution or fix. It's a limited hand because of the way the political cards are dealt. The best thing is probably to just stop at the discount card and low-income cash and get out of town. You have two more years before it kicks in. I don't think that Congress could really renege on the full package

approved to start in 2006. But that would be fine if you did that and you would actually solve the key problems.

Now, on the House side, Bill Thomas, chairman at Ways & Means, to a lesser degree, more grudgingly I think, has got the votes. His bill is at least trying to get toward a better version of full competitive bidding.

That's not thought of very well in the Senate, and I think the White House is pretty ambivalent on it as well. But that's about the last battleground for getting a morsel of reform out on this.

However, that phases in in 2010. They have to stuff a lot of money into the Medicare Plus Choice plans before then to boost their benchmark, and then, in effect, have them go above the fee-for-service before they set the bidding. But 2010 is too far off.

As I said before, President Hillary Clinton will have stopped that baby cold before it gets out of the box by 2009, and you have to accelerate the start of that. I know the votes are tough, but if you don't start that while George Bush is still President, maybe by 2007, you're not going to see that competitive bidding. It already was killed once before by Republican senators a couple of years ago at a demo level. Opposition to the real version of competitive bidding is too strong to think you're going to

get it all the way through, without a lot more force behind it.

And there is this worry that, well, if we do this, because of the people leaving fee-for-service and going to the private plans, and then we do the competitive bidding under the enrollment-weighted averaging, that means that the premiums for Part B and traditional Medicare will go up. I've heard this line of argument. Well, the Medicare premiums will go up anyway. They went up some 12 percent over the last year. I think in the next two years they're going to go up from \$58 a month to \$72 or \$74 a month. They still have to go up anyway. There is a ceiling on how much they can go, however, tied basically to annual Social Security benefit payment increases.

But the idea that traditional Medicare is going to stay that way forever and never change, you're guaranteed it will be that way; when the economics don't work, you either pay more or you get less of a benefit, even under the current program.

Now, a different way to go is to boost the private plans. Right now with the private plans, when they finally get on the table and do everything, if they bid lower, who gets the benefit of that lower bid? Well, right now 75 percent of it can go to the beneficiaries, whether

you do rebates or however you want to call it. And it means either you get more benefits, which is the old way, which isn't very efficient, or you get lower cost sharing. Technically it's about the same as cash unless you're at a zero premium. And 25 percent goes back to the government.

Well, if you want private plans to go there, why subsidize them for having higher costs? Why don't you just give 100 percent to the beneficiary and go ahead and let them have an incentive for choosing plans which do a better job, give a better value at a lower cost, even though you're not going to show any scoring gains in the Treasury if you want to subsidize that?

And also, if you're going to change the donut, don't do it at the upper end. Move it to the front end, where you start out. That's where the routine dollars are. And all of our economics in terms of cost sharing tells you that's the better place to make the sensitivity.

Our remaining alternatives are in partial fixes. We haven't said much about individual Medigap. That's a neglected market that is mismanaged. If you were not trying to go comprehensive and you had to go with what's on the table, there is a better way to reform the individual Medigap market that hasn't been focused on. You just throw

in a catastrophic drug benefit across all the coverages. And I know it's tough with the grandfathering and the ten approved varieties of Medigap insurance, but then you in effect could loosen up the cost sharing in the other provisions. Currently, there are 10 different coverage types, and most of them are either economically perverse or too costly. And that's how you adjust that.

You could swap benefits instead of putting more third party dollars on the table. If you want some more drugs, you take less of something else. You could do it through greater cost sharing. Or you simply stall until Congress runs out of the imaginary money that members think they are spending. And in about one more year, that would probably do that trick. I imagine the sticker shock and possibly further conflicts due to overreaching would be the only things to derail this. And maybe it's about time to end the pacifism in a one-sided intergenerational war. If you're firing in one direction, I don't hear anybody interested in coming back the other way.

The desired destination remains DC, but not the District of Columbia. It stands for defined contribution, although you can do the soft versions, called premium support.

Thank you. (Applause.)