TESTIMONY OF

LESLIE NORWALK
DEPUTY ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES

BEFORE THE

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

HEARING ON

FINANCING THE NEW MEDICARE DRUG BENEFIT

September 22, 2005

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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