United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

For Release on Delivery
Expected at 2:00 p.m.
Wednesday, September 22, 1999

MEDICARE REFORM

Ensuring Fiscal Sustainability While Modernizing the Program Will Be Challenging

Statement of David M. Walker
Comptroller General of the United States

GAO/T-HEHS/AIMD-99-294

Medicare Reform: Ensuring Fiscal Sustainability While Modernizing the Program Will Be Challenging

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss efforts to reform the administration, structure, and financing of Medicare–steps essential to maintaining the program's long-term solvency and to its modernization. There appears to be an emerging consensus that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. The long-term cost pressures facing this program are considerable. Fundamental program reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources.

Against this backdrop, I want to acknowledge your efforts, Mr. Chairman, as well as the contributions of the other members of the Bipartisan Commission on the Future of Medicare. The Breaux-Thomas proposal, which grew out of the Commission's deliberations, included a comprehensive reform plan on a technically difficult issue that touches on both the future health of beneficiaries and the fiscal health of the U.S. economy.[1] I also want to commend both this Subcommittee and the Congress as a whole for remaining steadfast in the face of intense pressure to roll back the Medicare payment reforms included in the Balanced Budget Act of 1997 (BBA). It is in no sense hyperbole to note that the BBA changes constituted a critical down payment for Medicare reform. I know that the Subcommittee appreciates the vital importance of waiting for strong evidence that demonstrates the need for any modifications before acting.

You must be especially prudent during this period of prosperity as you consider Medicare reform initiatives. Please remember that, even as recent estimates have increased the size of budget surpluses, these are projected budget surpluses, and we know that the business cycle has not been repealed. Current projected surpluses could well prove to be fleeting, and thus appropriate caution should be exercised when creating new entitlements that establish permanent claims on future resources. While I do not relish being the accountability cop at the surplus celebration party, that is part of my job as Comptroller General of the United States.

Moreover, while the size of future surpluses could exceed or fall short of projections, we know that demographic and cost trends will, in the

[1]The National Bipartisan Commission on the Future of Medicare held its last meeting on March 16, 1999. By a vote of 10 to 7, the Commission failed to achieve the 11-member super majority required by law to report a recommendation to the Congress.

absence of meaningful reform, drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers. Accordingly, we need to view this period of projected prosperity as an opportunity to address the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and meaningful reform less feasible.

As the foregoing suggests, the stakes associated with Medicare reform are high for the program itself and for the rest of the federal budget, both now and for future generations. Current policy decisions can help us prepare for the challenges of an aging society in several important ways: (1) reducing public debt to increase national savings and investment, (2) reforming entitlement programs to reduce future claims and free up resources for other competing priorities, and (3) establishing a more sustainable Medicare program that delivers effective and affordable health care to our seniors.

In this context, I would like to make a few summary points before delving into the specifics of Medicare's financial health and a discussion of potential reform.

- In March, the Bipartisan Commission on the Future of Medicare completed its deliberations. Reform options emerged from these and other discussions that touched on all aspects of the Medicare program, including (1) modernization of the traditional Medicare fee-for-service program, both to update the benefit package and enhance its potential for containing program costs; (2) modernization of the Medicare+Choice program to ensure that beneficiaries have health plan choices and allow the program to more efficiently purchase plan services; and (3) adoption of a program like the Federal Employees Health Benefits Program (FEHBP) or a premium support model to foster quality and price based competition among health plans and to elevate beneficiaries' consciousness about and responsibility for program costs.

Given the size of Medicare's unfunded liability, it is realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. The time to begin the difficult but necessary steps to reclaim our fiscal future is now, when we have budget surpluses and a demographic "holiday" with retirees a far smaller proportion of the population than they will be in the future.

Ideally, the unfunded promises associated with today's program should be addressed before or concurrent with proposals to make new ones, such as adding prescription drug coverage. To do otherwise might be politically

attractive but not fiscally prudent. If benefits are added, policymakers need to consider targeting strategies that fully offset the related costs. They may also want to design a mechanism to monitor aggregate program costs over time and to establish expenditure or funding thresholds that would trigger a call for fiscal action. Our history shows that when benefits are attractive, fiscal controls and constraints are difficult to maintain. In addition, any potential program expansion should be accompanied by meaningful reform of the current Medicare program to help ensure its sustainability.

To qualify as meaningful reform, a proposal should make a significant down payment toward ensuring Medicare's long-range financial integrity and sustainability–the most critical issue facing Medicare. The 1999 annual reports of the Medicare trustees project that program costs will continue to grow faster than the rest of the economy. Care must be taken to ensure that any potential expansion of the program is balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances. Proposals to reform Medicare should be assessed against the following criteria: affordability, equity, adequacy, feasibility, and acceptance. (See table 1.)

Table 1: Criteria for Assessing the Merits of Medicare Reform Proposals

Criterion	What this means for a proposal
Affordability	A proposal should be evaluated in terms of its effect on the long-term sustainability of Medicare expenditures
Equity	A proposal should be fair to providers and across groups of beneficiaries
Adequacy	A proposal should include resources that allow appropriate access and provisions that foster cost-effective and clinically meaningful innovations that address patients' needs
Feasibility	A proposal should incorporate elements that facilitate effective implementation and adequate monitoring
Acceptance	A proposal should be transparent and should educate provider and beneficiary communities about its costs and the realities of tradeoffs required by significant policy changes

People want unfettered access to health care, and some have needs that are not being met. However, health care costs compete with other legitimate priorities in the federal budget, and their projected future growth threatens to crowd out future generations' flexibility to decide which of these competing priorities will be met. Thus, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between wants, needs, and what both individuals

and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to issues affecting domestic programs. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations within a broader context of providing for other important national needs and economic growth.

Let's not kid ourselves—reforming Medicare is hard work. Health care spending accounts for one-seventh of the nation's economy, and Medicare is the nation's single largest health care payer. The program's beneficiary populations consist of roughly 35 million seniors and 4 million disabled individuals under age 65. The Health Care Financing Administration (HCFA) estimates that the program's billers—physicians, hospitals, equipment suppliers, and other providers of health services—number about 1 million.

As the various reform options come under scrutiny, the importance of design details should not be overlooked. Our work on efforts to implement reforms mandated in the BBA is instructive regarding reform specifics. Three principal lessons can be drawn from recent experience: (1) The particulars of payment mechanisms largely determine the extent to which a reform option can eliminate excess government spending while protecting beneficiaries access' to care. (2) Revisions to newly implemented policies should be based on a thorough assessment of their effects so that, at one extreme, they are not unduly affected by external pressures and premature conclusions or, at the other extreme, they remain static when change is clearly warranted. (3) For choice-based models to function as intended–that is, to foster competition based on cost and quality–consumers must have information that is sufficiently comparable.

At this time, I would like to discuss the competing concerns at the crux of Medicare reform, in general, and to provide a conceptual framework for considering the various possible combinations of reform options, in particular.

Competing Concerns Pose Challenges for Medicare Reform

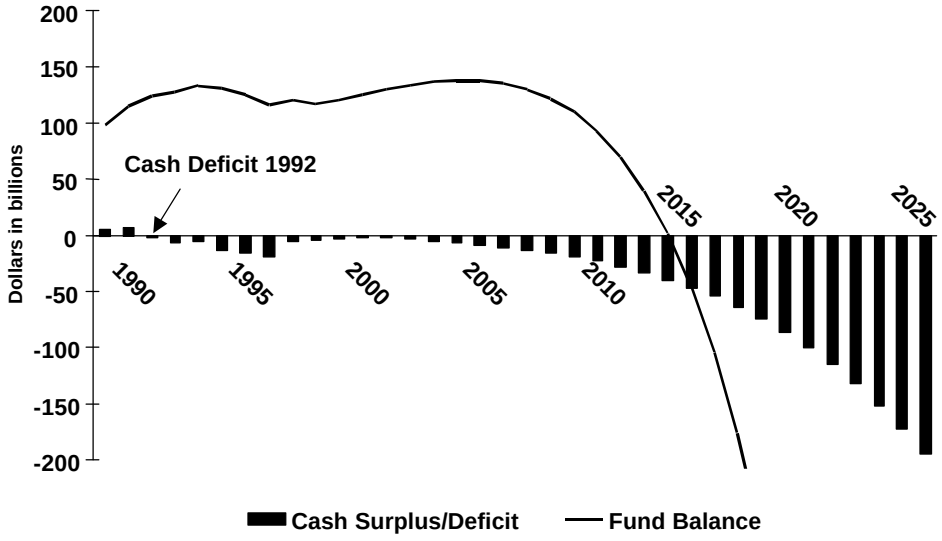
The current Medicare program, without improvements, is ill suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years. On the other, the program is outmoded in that it has not been able to adopt modern, market-based management tools, and its benefit package contains gaps in desired coverage compared to private employer coverage. Compounding the

difficulties of responding to these competing concerns is the sheer size of the Medicare program—even modest program changes send ripples across the program's 39-million-strong beneficiary population and the approximately 1 million health care providers that bill the program. Balancing the needs of all these parties requires hard choices that have been brought before this Subcommittee, the Congress, and the National Bipartisan Commission on the Future of Medicare.

Medicare Is Already in the Red

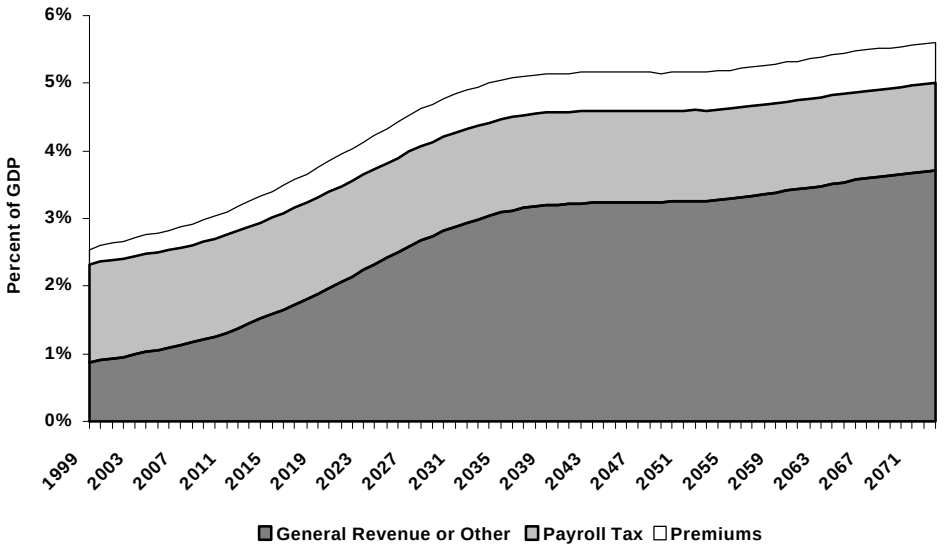
Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare Hospital Insurance (HI) Trust Fund—which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services—is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays. In serving the tracking purpose, annual trust fund reports show that Medicare's HI component is, on a cash basis, in the red and has been since 1992. (See fig. 1.) Currently, earmarked payroll taxes cover only 89 percent of HI spending and, including all earmarked revenue, the fund is projected to have a $7 billion cash deficit for fiscal year 1999 alone. To finance this deficit, Medicare has been drawing on its special issue Treasury securities acquired during the years when the program generated a cash surplus. Consequently, Medicare is already a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. In essence, for Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs, or reduce the projected surplus. Outlays for Medicare services covered under Supplementary Medical Insurance (SMI)–physician and outpatient hospital services, diagnostic tests, and certain other medical services and supplies–are already funded largely through general revenues.

Figure 1: Financial Outlook of the Hospital Insurance Trust Fund, 1990 to 2025



Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from 12 percent in 1999 to more than a quarter of all federal revenues by mid century. Over the same time frame, Medicare's expenditures are expected to double as a share of the economy, from 2.5 to 5.3 percent, as shown Fig. 2.

Figure 2: Composition of Medicare Funding as a Percent of Gross Domestic Product (GDP), 1999 to 2071

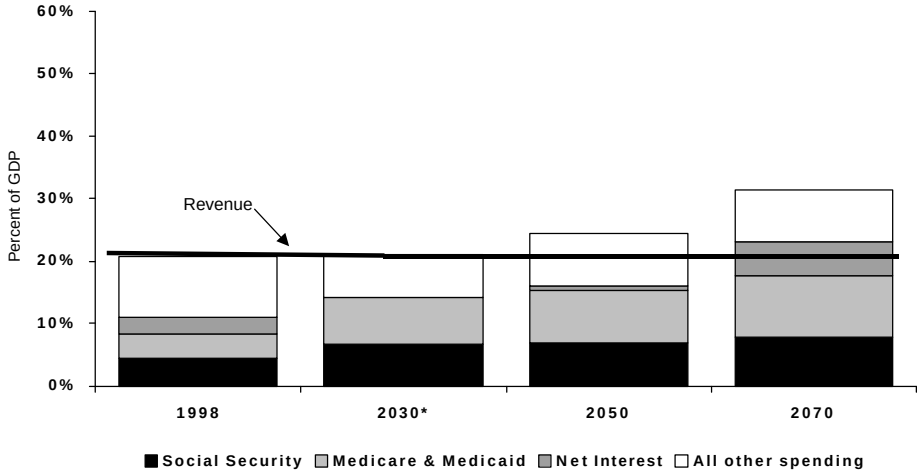


The progressive absorption of a greater share of the nation's resources for health care, like Social Security, is in part a reflection of the rising share of elderly in the population. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom. Today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages and the ratio of workers to retirees declines from 3.4 to one today to roughly two to one.

However, Medicare growth rates also reflect the escalation of health care costs at rates well exceeding general rates of inflation. Increases in the number and quality of health care services have been fueled by the explosive growth of medical technology. Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs. For these reasons, among others, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

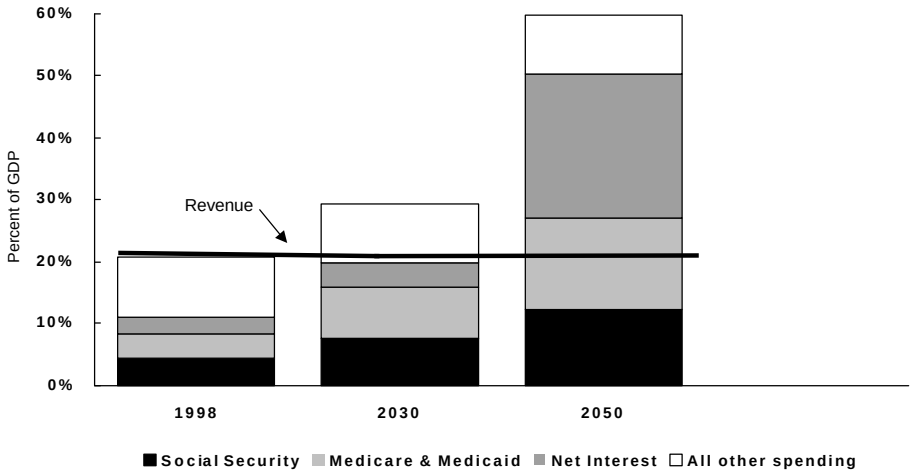
When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into the future without making changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Even assuming that all projected surpluses are saved and existing discretionary budget caps are complied with, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. (See fig. 3.) If none of the surplus is saved, the long-term outlook is even more daunting. (See fig. 4.) Budgetary flexibility declines drastically, and there is little or no room for programs for national defense, the young, infrastructure, and law enforcement. In short, there will be essentially no discretionary programs at all.

Figure 3: Composition of Spending as a Share of GDP Under "Save the Unified Surplus" Simulation



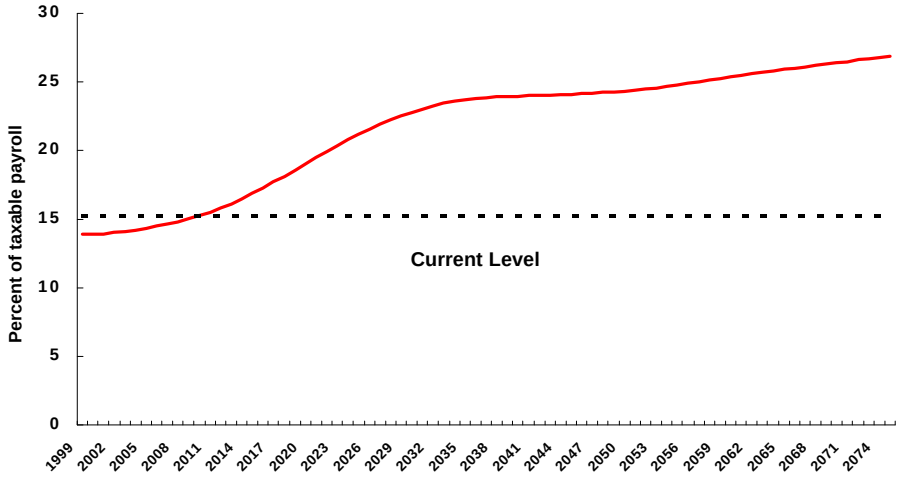
*In 2030, all other spending includes offsetting interest receipts.

Figure 4: Composition of Spending as a Share of GDP Under "No Unified Surplus" Simulation



When viewed together with Social Security, the financial burden of Medicare on the future taxpayers becomes unsustainable. As figure 5 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers.

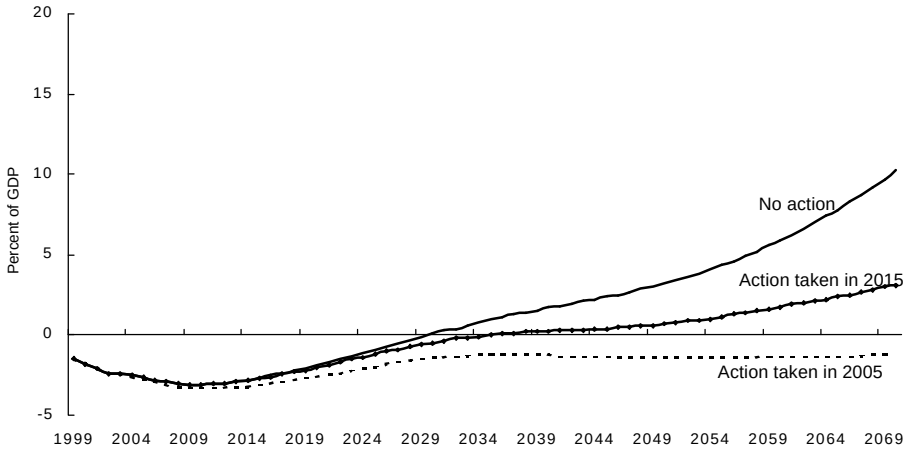
Figure 5: Social Security and Medicare HI as a Percent of Taxable Payroll, 1999 to 2074



While the problems facing the Social Security program are significant, Medicare's challenges are even more daunting. To close Social Security's deficit today would require a 17 percent increase in the payroll tax, whereas the HI payroll tax would have to be raised 50 percent to restore actuarial balance to the trust fund. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

Early action to address the structural imbalances in Medicare is critical. First, ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. Our long-term budget simulations, as shown in figure 6, illustrate how critical early action on Medicare reform is to our long-term fiscal future. If the annual growth in per person Medicare spending could be slowed to 4 percent over the 70-year period it would yield the kind of savings needed to establish a truly sustainable budget policy for the long term. This is not easy however. Although over 70 years the projected average annual growth in per person spending is 4.5 percent, over the next 10 years it is nearly 5 percent. The high projected growth of Medicare in the coming years, means that the earlier the reform begins, the greater the savings will be as a result of the effects of compounding. Reforms fully phased in by 2005 would enable us to maintain surpluses over the entire 70-year simulation period.

Figure 6: Federal Deficits as a Share of GDP Under Alternative Medicare Simulations, 1999 to 2069



The actions necessary to bring about a more sustainable program will no doubt call for some hard choices. Some suggest that the size of the imbalances between Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional resources. One possible source could be general revenues. Although this may eventually prove necessary, such additional financing should be considered as part of a broader initiative to ensure the program's long-range financial integrity and sustainability.

What concerns me most is that devoting general funds to the HI may be used to extend HI's solvency without addressing the hard choices needed to make the whole Medicare program more sustainable in economic or budgetary terms. Increasing the HI trust fund balance alone, without underlying program reform, does nothing to make the Medicare program more sustainable—that is, it does not reduce the program's projected share of GDP or the federal budget. From a macro economic perspective, the critical question is not how much a trust fund has in assets but whether the government as a whole has the economic capacity to finance all Medicare's promised benefits—both now and in the future.

If more fundamental program reforms are not made, I fear that general fund infusions would interfere with the vital signaling function that trust fund mechanisms can serve for policymakers about underlying fiscal imbalances in covered programs. The greatest risk is that dedicating

general funds to the HI program will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program. Furthermore, increasing the trust fund's paper solvency does not address cost growth in the SMI portion of Medicare, which is projected to grow even faster than HI in coming decades.

Long-Term Fiscal Policy Choices

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our nation's future capacity to afford paying benefits in the face of an aging society. Decisions on how we use today's surpluses can have wide-ranging impacts on our ability to afford tomorrow's commitments.

As we know, there have been a variety of proposals to use the surpluses for purposes other than debt reduction. Although these proposals have various pros and cons, we need to be mindful of the risk associated with using projected surpluses to finance permanent future claims on the budget, whether they are on the spending or tax side.[2] Commitments often prove to be permanent while projected surpluses can be fleeting. For instance, current projections assume full compliance with tight discretionary spending caps. Moreover, relatively small changes in economic assumptions can lead to very large changes in the fiscal outlook, especially when carried out over a decade. In a recent report, the Congressional Budget Office (CBO) compared the actual deficits or surpluses for 1988 through 1998 with the first projection it had produced 5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO says that its errors averaged about 13 percent of actual outlays. Such a shift in 2004 would mean a potential swing of about $250 billion in the projected surplus.

Although most would not argue for devoting 100 percent of the surplus to debt reduction over the next 10 years, saving a good portion of our surpluses would yield fiscal and economic dividends as the nation faces the challenges of financing an aging society. Our work on the long-term budget outlook illustrates the benefits of maintaining surpluses for debt reduction. Reducing the publicly held debt reduces interest costs, freeing up budgetary resources for other programmatic priorities. For the economy, running surpluses and reducing debt increase national saving and free up resources for private investment. These results, in turn, lead to stronger economic growth and higher incomes over the long term.

[2]See Federal Budget: The President's Midsession Review (GAO/OCG-99-29, July 21, 1999).

Over the last several years, our simulations illustrate the long-term economic consequences flowing from different fiscal policy paths.[3] Our models consistently show that saving all or a major share of projected budget surpluses ultimately leads to demonstrable gains in GDP per capita. Over a 50-year period, GDP per capita would more than double from present levels by saving all or most of projected surpluses, while incomes would eventually fall if we failed to sustain any of the surplus. Although rising productivity and living standards are always important, they are especially critical for the 21st century, for they will increase the economic capacity of the projected smaller workforce to finance future government programs along with the obligations and commitments for the baby boomers' retirement.

BBA Made Medicare Reform Down Payment

In addition to its significant financial imbalance, Medicare is outmoded from a programmatic perspective. In its current form, the program lacks the flexibility to readily adjust its administered prices and fees in line with market rates and lacks the tools to exercise meaningful control over the volume of services used. Nevertheless, BBA reforms enacted in 1997 have begun to address certain programmatic shortcomings by modernizing the program's pricing and payment strategies and by moving toward quality-based competition among health plans. The act's combination of structural reforms, constraints on provider fees, and increases in beneficiary payments was expected to lower program spending by $386 billion over 10 years. Because certain key provisions have only recently or have not yet been phased in, the full effects of the BBA on providers, beneficiaries, and taxpayers will not be known for some time.

Of particular significance was BBA's creation of the Medicare+Choice program, which furthered the use of a choice-based model of providing Medicare benefits. Medicare+Choice expanded Medicare's managed care options to include, in addition to health maintenance organizations (HMO), health plans such as preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. In making this expanded consumer choice program, BBA provisions placed a dramatic new emphasis on the development and dissemination of comparative plan information to consumers to foster quality-based plan competition. Other BBA provisions were designed to pay health plans more appropriately than Medicare had done under the previous HMO payment formula.

[3]See Budget Issues: Long-Term Fiscal Outlook (GAO/T-AIMD/OCE-98-83, Feb. 25, 1998) and Budget Issues: Analysis of Long-Term Fiscal Outlook (GAO/AIMD/OCE-98-19, Oct. 22, 1997).

BBA also made historic changes to traditional Medicare. It is gradually eliminating, for the most part, cost-based reimbursement methods and replacing them with prospective payment systems (PPS). The intent is to foster the more efficient use of services and to lower growth rates in spending for these providers, replicating the experience for acute care hospitals following the implementation of Medicare's PPS for hospitals, which began in the mid-1980s. BBA mandated phasing in PPSs for skilled nursing facilities, home health agencies (HHA), hospital outpatient services, and certain hospitals not already paid under such arrangements.

Yet pressures mount to undo some of these changes. Affected providers are currently seeking to repeal various BBA provisions, some relying on anecdotal evidence rather than systematic analysis to make their case. An illustration is the reporting of health plan withdrawals from the Medicare+Choice program for 1999. Plans cite, and the press reports, inadequate payment rates as the reason for dropping out of Medicare or reducing enrollees' benefits. We have another point of view based on our fact-gathering and analyses.

BBA sought to moderate Medicare's payments to managed care plans because, ironically, Medicare managed care cost, not saved, the government money. That is, the government was paying more to cover beneficiaries in managed care than it would have if these individuals had remained in the traditional fee-for-service program. In our report, we noted that BBA has reduced, but not eliminated, excess payments.[4] In fact, Medicare's payments to some plans are generous enough for plans to make profits and to finance prescription drugs and other extras not available to the majority of senior and disabled beneficiaries who remain in traditional Medicare. We have also reported that factors additional to or even exclusive of payment rates—including competition and other market conditions—played a significant role in the 1999 plan dropouts.[5] Our ongoing analysis of the year 2000 plan dropouts reveals similar findings. The question this raises for policymakers is the extent to which they should be concerned about health plan dropouts from Medicare when plan participation means that the government finances non-Medicare benefits for a minority of beneficiaries while paying more for these beneficiaries than for similar ones in traditional Medicare. Among other lessons, however, the intensity of pressure to roll back BBA's curbs on managed

[4]See Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments (GAO/HEHS-99-144, June 18, 1999).

[5]See Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues (GAO/HEHS-99-91, Apr. 27, 1999).

care rate increases teaches us the difficulty that this Subcommittee and the Congress as a whole face in making Medicare payment reforms.

Dimensions of Reform Include Benefit Expansions and Financing Changes

Concern continues to be voiced about the obvious gaps in protections for Medicare beneficiaries, in contrast to what is available for most individuals with private employer-based coverage. At the same time, competing concerns remain about the need to check Medicare's cost growth, even without adding new benefits. In response, the various reform options, including those favored by a majority of the Bipartisan Commission, have two major dimensions: (1) expansion of Medicare's benefit package and (2) cost containment through financing and other structural transformations. Two commonly discussed benefit expansions are the inclusion of a prescription drug benefit and coverage for extraordinary out-of-pocket costs, known as catastrophic coverage. The financing reforms are reflected in three models: fee-for-service modernization, Medicare+Choice modernization, and a premium support system fashioned after FEHBP. Each of these models is designed, to different degrees, to alter program incentives currently in place to make beneficiaries more cost conscious and providers more efficient (See table 2).

Table 2: Major Dimensions of Medicare Reform, by Option

Updated benefit package options	Financing and organizational change options
Coverage for outpatient prescription drugs	Fee-for-service modernization
Limit on beneficiary liability	Medicare+Choice modernization
	FEHBP-type premium support

Benefit Expansion Reforms

Medicare's basic benefit package largely reflects the offerings of the commercial insurance market in 1965 when the program began. Although commercial policies have evolved since then, Medicare's package—for the most part—has not.[6] For example, unlike many current commercial policies, Medicare does not cover outpatient prescription drugs or cap beneficiaries' annual out-of-pocket spending. Some beneficiaries can augment their coverage by participating in the Medicaid program (if their

[6]Some Medicare benefits have changed. For example, BBA added or expanded coverage for screening mammograms, prostate cancer screening tests, bone mass measurements, and several screening or preventive services.

incomes are low enough), obtaining a supplemental insurance policy privately or through an employer, or enrolling in a Medicare+Choice plan. However, these options are not available to or affordable for all beneficiaries. Furthermore, to the extent that Medicaid and supplemental policies provide first-dollar coverage of services, the beneficiary population's sensitivity to service costs is dulled, contributing to some continued excess utilization. Consequently, many reform advocates believe that Medicare's basic benefit package should be brought into line with current commercial norms for active workers.

Two benefit reforms under discussion by policymakers are the inclusion of prescription drugs and stop-loss coverage that caps beneficiary out-of-pocket spending. Each involves myriad options, and assessing the merit of these reforms would depend on the specifics included. For instance, a Medicare prescription drug benefit could be targeted to provide coverage for all beneficiaries, coverage only for beneficiaries with extraordinary drug expenses, coverage only for low-income beneficiaries, or coverage for selected drugs, such as those deemed to be cost beneficial. Such coverage decisions would hinge on understanding how a new pharmaceutical benefit would shift to Medicare portions of the out-of-pocket costs borne by beneficiaries as well as those costs paid by Medicaid, Medigap, or employer plans covering prescription drugs for retirees. How would these new program costs be shared between taxpayers and beneficiaries through premiums, deductibles, and copayments? Would subsidies be provided to help low-income beneficiaries not eligible for Medicaid with these costs? The administration of the benefit raises other questions, such as "Who would set and enforce drug coverage standards among the private health plans participating in Medicare?" and, for traditional Medicare, "How would reimbursable prices be set?" Price-setting options include using a formula based on market prices, negotiating directly with manufacturers, or contracting with pharmaceutical benefit management companies. The Breaux-Thomas proposal favored targeting a drug benefit to low-income beneficiaries while allowing those at higher incomes to buy into the benefit. A catastrophic, or stop-loss, coverage benefit would similarly entail its own design permutations and variables.

Financing and Other Structural Reforms

Many Medicare reforms are designed to slow spending growth to keep the program viable for the nation's growing aged population. Although the various proposals, including those considered by the Bipartisan Commission, differ from one another in concept, they generally include mechanisms to make beneficiaries more cost conscious, and incorporate provider incentives to improve the efficiency of health care delivery. The

various financing and structural reforms consist of components of three general models: fee-for-service modernization, Medicare+Choice modernization, and a premium support system fashioned after FEHBP (See table 3).

Table 3: Three Medicare Financing and Structural Reforms

	Fee-for-service modernization	Medicare+Choice modernization	FEHBP-type premium support
Pending under BBA	Prospective payment systems for HHAs, hospital outpatient departments, and others	Health-based risk adjustment of rates Annual enrollment and lock-in Competitive pricing demonstration	
Potential under current proposals	Selective purchasing Negotiated pricing Case management for complex and chronic conditions Utilization management Medigap and beneficiary cost-sharing reforms Expanded use of centers of excellence	Plan savings shared with program and/or beneficiaries Competitive premium pricing	Premium based on offered or negotiated price Beneficiary contribution based on plan cost Traditional Medicare incorporated Enhanced flexibility Self-financed

Fee-for-Service Modernization

BBA improved the efficiency of Medicare's traditional fee-for-service program by substituting a variety of PPSs and other fee changes for its cost-based reimbursement methods and outdated fees. Nevertheless, Medicare is still not an efficient purchaser. Adjusting its systems of administered prices and fees up or down to ensure beneficiary access or to capture potential savings as the market changes poses an overwhelming, if not impossible, challenge. Medicare largely remains a passive bill payer, exercising little meaningful control over the volume of services used. Proposals to modernize fee-for-service Medicare aim at

providing flexibility to take advantage of market prices and introducing some management of service utilization. In proposing to make fee-for-service more fiscally accountable and to provide it with additional flexibility to achieve these fiscal goals, the Bipartisan Commission also discussed fee-for-service modernization as one of the critical elements of reform.

Preferred provider arrangements, whereby insurers select certain providers because of their willingness to accept lower fees and their efficient style of practice, have become commonplace in the commercial insurance market. By accepting negotiated or competitively bid fees that fall below the usual levels, selected providers and the beneficiaries using their services would be afforded certain advantages. The selected providers with lower fees may experience increased demand, while beneficiaries using their services could be subject to lower cost sharing. Comparable arrangements have been proposed for fee-for-service Medicare. Testing of this concept has been under way in the HCFA's Centers of Excellence demonstrations, where hospitals and physicians agree to provide certain procedures for negotiated all-inclusive fees. BBA also allowed for testing of competitive bidding for medical equipment and supplies, with high bidders being excluded from serving Medicare beneficiaries.

About 87 percent of beneficiaries in traditional Medicare face little cost sharing in the form of deductibles or copayments for services by virtue of their eligibility for Medicaid or their enrollment in a supplementary insurance plan. While increases in cost sharing have been common in private insurance to make beneficiaries sensitive to the value and cost of services, it has been a cost-containment tool largely unavailable to Medicare. Protecting low-income beneficiaries from financial barriers to care remains a critical concern. One possible change in allowable supplementary coverage would be to restructure cost sharing to heighten beneficiary sensitivity to the cost of services while removing catastrophic costs for those who have intensive health care needs.

Private indemnity insurers have moved to incorporate certain utilization management techniques into their policies, such as prior authorization of some expensive services and case management for persons with serious chronic conditions. Although such techniques are increasingly common among private insurers, their effectiveness on the population Medicare covers is unknown.

Medicare+Choice Modernization

Medicare+Choice signaled a new phase in efforts to transform Medicare. Built on the program that allowed beneficiaries to enroll in participating

managed care plans, Medicare+Choice expands options available to beneficiaries and substantially changes plan payment methods. By raising payments in certain areas and allowing additional types of entities to contract with Medicare, Medicare+Choice is intended to boost plan participation and beneficiary enrollment. Payment changes are designed to adjust the per capita rates to more accurately reflect enrollees' expected resource use and slow the growth of spending over time.

Among other payment changes, BBA required HCFA to implement by January 1, 2000, a methodology to adjust plan payments to reflect the health status of plan members. Favorable selection—that is, the tendency for healthier beneficiaries to enroll in managed care plans—has resulted in payments that are higher than warranted. The new risk adjustment method developed for Medicare will more closely align payments to the expected health care costs of plans' enrollees. This will help produce the savings originally envisioned when managed care enrollment options were offered to Medicare beneficiaries and will foster competition among plans on the basis of benefits and quality rather than enrollment strategies.

The design of the Medicare+Choice program does not, however, allow taxpayers to benefit from the current competition among health plans. If a plan can provide the Medicare package of benefits for less than the Medicare payment, it must cover additional benefits, reduce fees, or both.[7] Plans that offer enriched benefit packages—such as including coverage for outpatient prescription drugs or routine physical examinations—may attract beneficiaries and gain market share. Medicare, however, pays the predetermined price even in fiercely competitive markets.

The Medicare+Choice program could be modified, through new legislation, to require that taxpayers and beneficiaries both benefit from health plan competition. The Congress could require that when payments exceed a plan's cost of services (including reasonable profit), part of the savings be returned to the program and the rest be used to fund additional benefits. Another alternative would be to set plan payments through competitive bidding. In fact, BBA mandates a competitive pricing demonstration. However, setting the parameters of a competitive pricing system is a formidable task. Furthermore, this payment-setting approach may be best suited to urban areas with high concentrations of managed care members.

[7]Alternatively, plans can contribute to a stabilization fund that would allow them to provide additional benefits or lower fees in future years. Before BBA, health plans also had the option of accepting a lower capitation payment. In practice, plans preferred to add benefits to attract beneficiaries.

FEHBP-Type Premium Support

Although modernizing traditional Medicare and Medicare+Choice could improve the control of program spending, several incentives would remain unaltered. For example, beneficiaries would remain partially insulated from the cost consequences of their choices. They would not benefit directly from selecting plans capable of delivering Medicare-covered benefits less expensively because the premiums they pay might well remain constant. Program payments to plans would continue to be established administratively. The Breaux-Thomas proposal recognized beneficiary sensitivity to cost as the critical element missing from the current Medicare program. To remedy this situation, the Breaux-Thomas proposal and others have proposed the adoption of an FEHBP-type premium support for Medicare—a mechanism that could, at the same time, serve to increase beneficiary sensitivity to the cost consequences of their choices and enhance quality/cost based competition.

The two defining elements of an FEHBP-type of premium support are (1) the establishment of premium levels for plans through negotiations between the program and plans and (2) the linking of beneficiaries' contributions to the premiums of the plans they join. This system makes transparent to beneficiaries which plans operate less expensively and can therefore charge lower premiums. In principle, it encourages competition because plans that can deliver services more efficiently can lower premiums and attract more enrollees. In practice, some caveats remain. Differences in premiums can reflect more than variation in efficiency. For example, plans may achieve savings through narrower provider networks that, while capable of providing Medicare-covered benefits, could cause beneficiaries inconveniences and delays in accessing services. Providing beneficiaries adequate comparative information on plans' expected and actual performance becomes even more critical.

Because most beneficiaries participate—and are expected to continue to participate—in traditional fee-for-service Medicare, its incorporation into the FEHBP-type system is seen as important. Under current arrangements, the only premium for participating in the traditional program is the fixed monthly amount that beneficiaries voluntarily pay to receive coverage for SMI or to be eligible to enroll in a Medicare+Choice plan. Because the premium amount represents only 25 percent of the program's cost and is deducted from beneficiaries' monthly Social Security payments, participants are not as aware of the cost of the traditional Medicare program. The Breaux-Thomas proposal incorporates traditional Medicare as another plan under an FEHBP-type premium support system. Traditional Medicare would propose and negotiate premiums like any other plan and be expected to be self-financing and self-sustaining. Recognizing the challenge the latter requirement creates, the proposal

would also provide traditional Medicare more flexibility to manage costs using tools similar to proposals for fee-for-service modernization.

Incorporating traditional Medicare as another plan puts all plans on equal footing and maximizes beneficiaries awareness of costs. However, the sheer size of the traditional program creates questions. How much flexibility can be granted to traditional Medicare, given its market power? What will it mean for a public plan to be self-sustaining and self-financing? Can it generate and retain reserves as a protection against future losses? How will losses be managed? The insolvency of traditional Medicare, which may continue to enroll the majority of beneficiaries and may be the only plan serving many areas of the country, is not acceptable. The dilemma of how to guarantee traditional Medicare's solvency in the context of an FEHBP-type premium support system needs to be addressed.

An FEHBP-type premium support system would increase the importance of effective program management and design. In particular, the ability to risk-adjust premiums to reflect the variation in health status of beneficiaries joining different plans would become paramount. Participating plans that attract a disproportionate number of more seriously ill and costly beneficiaries would be at a competitive disadvantage if their premium revenues were not adjusted adequately. In turn, enrollees in those plans might find services compromised by the plans' financial situation. Inadequate risk adjustment may be a particular problem for the traditional Medicare plan, which may function as a refuge for many chronically ill persons who find selecting among plans challenging and opt for something familiar.

Concluding Observations

In determining how to reform the Medicare program, much is at stake—not only the future of Medicare itself but also assuring the nation's future fiscal flexibility to pursue other important national goals and programs. Mr. Chairman, I feel that the greatest risk lies in doing nothing to improve the program's long-term sustainability or, worse, in adopting changes that may aggravate the long-term financial outlook for the program and the budget.

It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Relieving them of some of the burden of today's financing commitments would help fulfill this generation's fiduciary responsibility. It would also preserve some capacity to make their own choices by strengthening both the budget and the economy they inherit. While not ignoring today's needs and demands, we

should remember that surpluses can be used as an occasion to promote the transition to a more sustainable future for our children and grandchildren.

General fund infusions and expanded benefits may well be a necessary part of any major reform initiative. Updating the benefit package may be a necessary part of any realistic reform program to address the legitimate expectations of an aging society for health care, both now and in the future. Such changes, however, need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. In addition, the Congress should consider adequate fiscal incentives to control costs and a targeting strategy in connection with any proposal to provide any new benefit such as prescription drugs.

I am under no illusions about how difficult Medicare reform will be. The Breaux-Thomas proposal addresses the principal elements of reform, but many of the details need to be worked out. Those details will determine whether reforms will be both effective and acceptable—that is, seen as guaranteeing the sustainability and preservation of the Medicare entitlement, a key goal on which there appears to be consensus. Experience shows that forecasts can be far off the mark. Benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. Recent experience implementing BBA reforms provides us some sobering lessons about the difficulty of undertaking reform and the need for effectiveness, flexibility, and steadfastness. Effectiveness involves collecting the data necessary to assess impact—separating the transitory from the permanent and the trivial from the important. Flexibility is critical to make changes and refinements when conditions warrant and when actual outcomes differ substantially from the expected ones. Steadfastness is needed when particular interests pit the primacy of their needs against the more global interest of making Medicare affordable, sustainable, and effective for current and future generations of Americans. This makes it all the more important that any new benefit expansion be carefully designed to balance needs and affordability, both now and over the longer term.

The bottom line is that surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a stewardship responsibility to future generations to reduce the debt burden they inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both

adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large. National saving pays future dividends over the long term but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead time to phase in changes and before the changes that are needed become dramatic and disruptive. The prudent use of the nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Subcommittee may have.

GAO Contacts and Acknowledgments

If you have any questions regarding this testimony, please call Paul L. Posner, Director of Budget Issues, at (202) 512-9573 or William J. Scanlon, Director of Health Financing and Public Health Issues at (202) 512-7114. Other individuals who made key contributions include Linda F. Baker, James Cosgrove, Hannah F. Fein, James R. McTigue, Walter Ochinko, and Deborah Spielberg.

(101896/935333)

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St.,NW (Corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (202) 512-6061 or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

Info@www.gao.gov

or visit GAO's World Wide Web Home Page at

http://www.gao.gov

United States
General Accounting Office
Washington, DC 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested