United States General Accounting Office

GAO

Testimony

Before the Committee on the Budget, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, July 25, 2001

MEDICARE

New Spending Estimates Underscore Need for Reform

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





GAO-01-1010T

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the long-term financial condition of the Medicare program. In previous congressional testimony over the past several years, I have consistently stressed that without meaningful reform, demographic and cost trends will drive Medicare spending to unsustainable levels.[1] These trends highlight the need to act now rather than later when needed changes will be increasingly more painful and disruptive.

Although the short-term outlook of Medicare's Hospital Insurance trust fund improved somewhat in the last year, the long-term projections are much worse due to a change in expectations about future health care costs. Specifically, the Medicare Trustees' latest projections released in March incorporate more realistic—i.e., higher—assumptions about long-term health care spending. As a result, the long-term outlook for Medicare's financial future—both Hospital Insurance (HI) and Supplementary Medical Insurance (SMI)—is considerably worse than previously estimated. The Congressional Budget Office (CBO) also increased its long-term estimates of Medicare spending. The slowdown in Medicare spending growth that we have seen in recent years appears to have come to an end. In the first 8 months of fiscal year 2001, Medicare spending was 7.5 percent higher than the previous year. The fiscal discipline imposed through the Balanced Budget Act of 1997 (BBA) continues to be challenged, while interest in modernizing the Medicare benefits package to include prescription drug coverage has increased. Taken together, these developments mean higher, not lower health care cost growth. They reinforce the need to begin taking steps to address the challenges of meaningful Medicare reform. In pursuing such reform, it is important to focus on the long-term sustainability of the combined Medicare program, rather than the solvency of the HI trust fund alone.

Ultimately, any comprehensive Medicare reform must confront several fundamental challenges. In summary:

[1] *Medicare: Higher Expected Spending and Call for New Benefit Underscore Need for Meaningful Reform* (GAO-01-539T, March 22, 2001); *Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead* (GAO/T-HEHS-AIMD-00-103, Feb. 24, 2000); *Medicare Reform: Ensuring Fiscal Sustainability While Modernizing the Program Will Be Challenging* (GAO/T-HEHS/AIMD-99-294, Sept. 22, 1999).

- Medicare spending is likely to grow faster than previously estimated. The Medicare Trustees are now projecting that, in the long- term, Medicare costs will eventually grow at 1 percentage point above per-capita gross domestic product (GDP) each year—about 1 percentage point faster per year than the previous assumption. Accordingly, as estimated by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS)—formerly known as the Health Care Financing Administration (HCFA), the estimated net present value of future additional resources needed to fund Part A HI benefits over the next 75 years increased from $2.6 trillion last year to $4.6 trillion this year—an increase of more than 75 percent.
- Our long-term budget simulations show that demographics and health care spending will drive us back into periods of escalating deficits and debt absent meaningful entitlement reforms or other significant tax or spending actions. Our March 2001 long-term simulations show that even if the often-stated goal of saving all Social Security surpluses is realized, large and persistent deficits will return in less than 20 years.
- Medicare's sustainability can no longer be measured merely using the traditional measure of HI trust fund solvency. The financial status of this trust fund does not reflect the whole picture. In fact, focusing on solvency can be misleading and give a false sense of security regarding the overall condition of the Medicare program. Both Part A expenditures financed through payroll taxes and Part B SMI expenditures financed through general revenues and beneficiary premiums must be taken into consideration. When viewed from this comprehensive perspective, total Medicare spending is projected to double as a share of GDP by 2035. Importantly, this estimate does not include the cost of any prescription drug benefit.
- Since the cost of a drug benefit would boost these spending projections even further, adding prescription drug coverage will require difficult policy choices that will likely have significant effects on beneficiaries, taxpayers, and the program. Recognition of who bears the cost of Medicare is critical. Currently, there may not be full awareness that beneficiaries' payroll tax contributions and premiums generally finance considerably less than their lifetime benefits.
- Properly structured reforms to promote competition among health plans can help make beneficiaries more cost conscious. However, improvements to traditional fee-for-service (FFS) Medicare are also critical, as it will likely remain dominant for some time to come.
- Fiscal discipline is difficult, but the continued importance of traditional Medicare underscores the need to base adjustments to provider payments on hard evidence rather than anecdotal information and to carefully target relief where it is both needed and deserved.

- Similarly, reform of Medicare's management, which is on the table as discussions of Medicare program reforms proceed, will require carefully targeted efforts to ensure that adequate resources are appropriately coupled with improved performance and increased accountability.
- Ultimately, we will need to look at broader health care reforms to balance health care spending with other societal priorities. In doing this, it is important to look at the entire range of federal policy tools—tax policy, spending, and regulation. It is also important to note the fundamental differences between health care wants, which are virtually unlimited, from needs, which should be defined and addressed, and overall affordability, of which there is a limit. In the end, we will need to take a range of steps to increase the transparency of health care costs and quality, target assistance to those in need, re-examine incentives, and assure accountability for desired outcomes.

The consensus that Medicare is likely to cost more than previously estimated serves to reinforce the need to act soon. Realistically, reforms to address the Medicare program's huge long-range financial imbalance will need to proceed incrementally. In addition, efforts to update the program's benefits package will need careful and cautious deliberation. As the Congress considers Medicare reform, it will be important to adopt effective cost containment reforms alongside potential benefit expansions. Any benefit expansion efforts will need to be coupled with adequate program reforms if Medicare's long-range financial condition is not to be worsened. This is especially important in connection with a potential prescription drug benefit, as this coverage represents the fastest-growing expenditure for many public and private health plans. Therefore, the time to begin these difficult, but necessary, incremental steps is now.

Medicare's Long-Term Financial Future Looks Worse

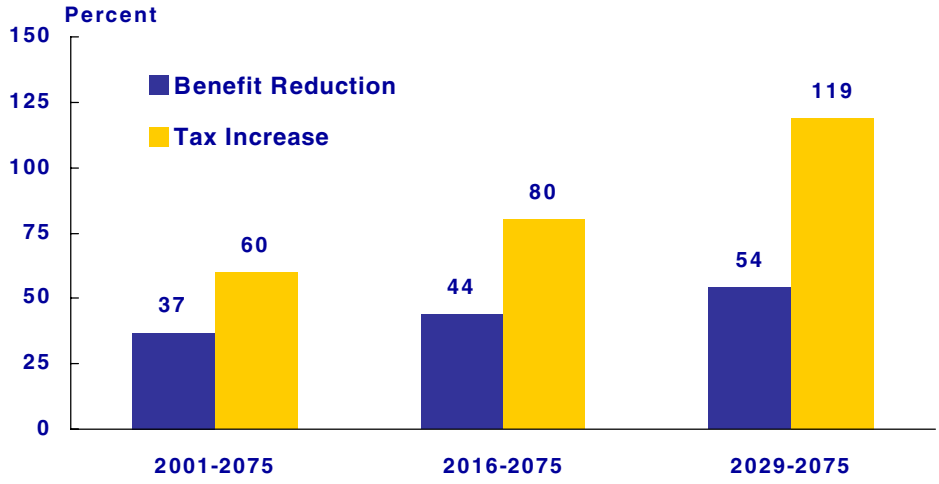
As I have stated in other testimony, Medicare as currently structured is fiscally unsustainable. While many people have focused on the improvement in the HI trust fund's shorter-range solvency status, the real news is that we now have a more realistic view of Medicare's long-term financial condition and the outlook is much bleaker. A consensus has emerged that previous program spending projections have been based on overly optimistic assumptions and that actual spending will grow faster than has been assumed.

Traditional HI Trust Fund Solvency Measure Is a Poor Indicator of Medicare's Fiscal Health

First, let me talk about how we measure Medicare's fiscal health. In the past, Medicare's financial status has generally been gauged by the projected solvency of the HI trust fund, which covers primarily inpatient hospital care and is financed by payroll taxes. Looked at this way, Medicare—more precisely, Medicare's Hospital Insurance trust fund—is described as solvent through 2029.

However, even from the perspective of HI trust fund solvency, the estimated exhaustion date of 2029 does not mean that we can or should wait until then to take action. In fact, delay in addressing the HI trust fund imbalance means that the actions needed will be larger and more disruptive. Taking action today to restore solvency to the HI trust fund for the next 75 years would require benefit cuts of 37 percent or tax increases of 60 percent, or some combination of the two. While these actions would not be easy or painless, postponing action until 2029 would require more than doubling of the payroll tax or cutting benefits by more than half to maintain solvency. (See fig. 1.) Given that in the long-term, Medicare cost growth is now projected to grow at 1 percentage point faster than GDP, HI's financial condition is expected to continue to worsen after the 75-year period. By 2075, HI's annual financing shortfall—the difference between program income and benefit costs—will reach 7.35 percent of taxable payroll. This means that if no action is taken this year, shifting the 75-year horizon out one year to 2076—a large deficit year—and dropping 2001—a surplus year—would yield a higher actuarial deficit, all other things being equal.

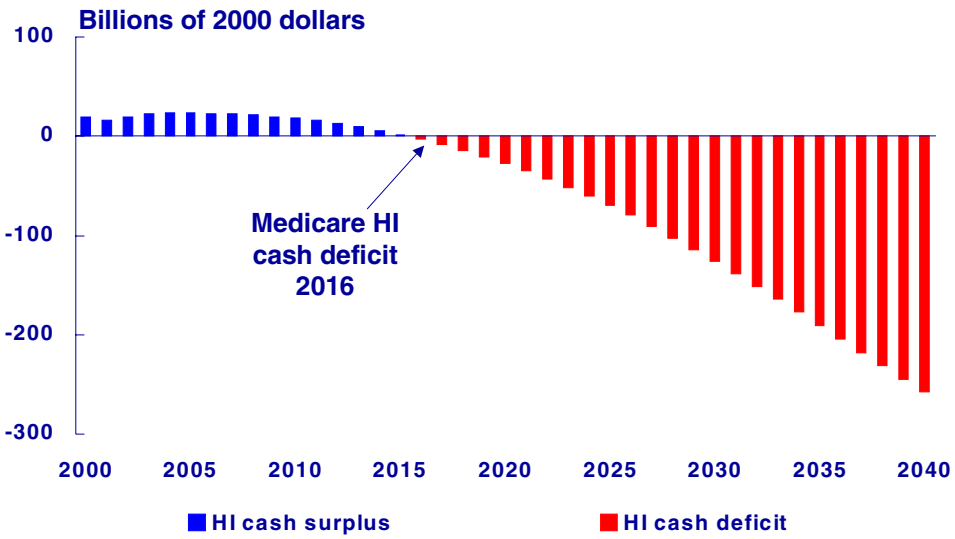
Figure 1: Estimated Benefit Reduction or Tax Increase Necessary to Restore HI Trust Fund Solvency



Source: Office of the Actuary, CMS, 2001 intermediate assumptions.

Moreover, HI trust fund solvency does not mean the program is financially healthy. Under the Trustees' 2001 intermediate estimates, HI outlays are projected to exceed HI tax revenues beginning in 2016, the same year in which Social Security outlays are expected to exceed tax revenues. (See fig. 2.) As the baby boom generation retires and the Medicare-eligible population swells, the imbalance between outlays and revenues will increase dramatically. Thus, in 15 years the HI trust fund will begin to experience a growing annual cash deficit. At that point, the HI program must redeem Treasury securities acquired during years of cash surplus. Treasury, in turn, must obtain cash for those redeemed securities either through increased taxes, spending cuts, increased borrowing, retiring less debt, or some combination thereof.

Figure 2: Medicare's Hospital Insurance Trust Fund Faces Cash Deficits as Baby Boomers Retire



Source: GAO analysis of data from the Office of the Actuary, CMS, 2001 intermediate assumptions.

Finally, HI trust fund solvency does not measure the growing cost of the Part B SMI component of Medicare, which covers outpatient services and is financed through general revenues and beneficiary premiums.[2] Part B accounts for somewhat more than 40 percent of Medicare spending and is expected to account for a growing share of total program dollars. As the Trustees noted in this year's report, a rapidly growing share of general revenues and substantial increases in beneficiary premiums will be required to cover part B expenditures.

[2]At Medicare's inception, the law initially established a formula for Part B premiums that set the rate to cover 50 percent of expected program costs for aged enrollees, with the remaining 50 percent covered by general revenues. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which Social Security benefits were adjusted for changes in cost of living. As a result, from the mid-1970s through the early 1980s, the portion of program costs covered by premium income dropped from 50 percent to below 25 percent. Beginning in the early 1980s, Congress regularly voted to set part B premiums at a level to cover 25 percent of expected program costs, in effect overriding the cost-of-living adjustment limitation. In 1997 BBA permanently set the rate at 25 percent.

Clearly, it is total program spending—both Part A and Part B—relative to the entire federal budget and national economy that matters. This total spending approach is a much more realistic way of looking at the combined Medicare program's sustainability. In contrast, the historical measure of HI trust fund solvency cannot tell us whether the program is sustainable over the long haul. Worse, it can serve to distort perceptions about the timing, scope, and magnitude of our Medicare challenge.

New Estimates Increase Urgency of Reform Efforts

These figures reflect a worsening of the long-term outlook. Last year a technical panel advising the Medicare Trustees recommended assuming that future per-beneficiary costs for both HI and SMI eventually will grow at a rate 1 percentage point above GDP growth—about 1 percentage point higher than had previously been assumed.[3] That recommendation—which was consistent with a similar change CBO had made to its Medicare and Medicaid long-term cost growth assumptions[4]—was adopted by the Trustees. In their new estimates published on March 19, 2001, the Trustees adopted the technical panel's long-term cost growth recommendation.[5] The Trustees note in their report that this new assumption substantially raises the long-term cost estimates for both HI and SMI. In their view, incorporating the technical panel's recommendation yields program spending estimates that represent a more realistic assessment of likely long-term program cost growth.

Under the old assumption (the Trustees' 2000 best estimate intermediate assumptions), total Medicare spending consumed 5 percent of GDP by 2063. Under the new assumption (the Trustees' 2001 best estimate intermediate assumptions), this occurs almost 30 years sooner in 2035—and by 2075 Medicare consumes over 8 percent of GDP, compared with 5.3 percent under the old assumption. The difference clearly demonstrates the

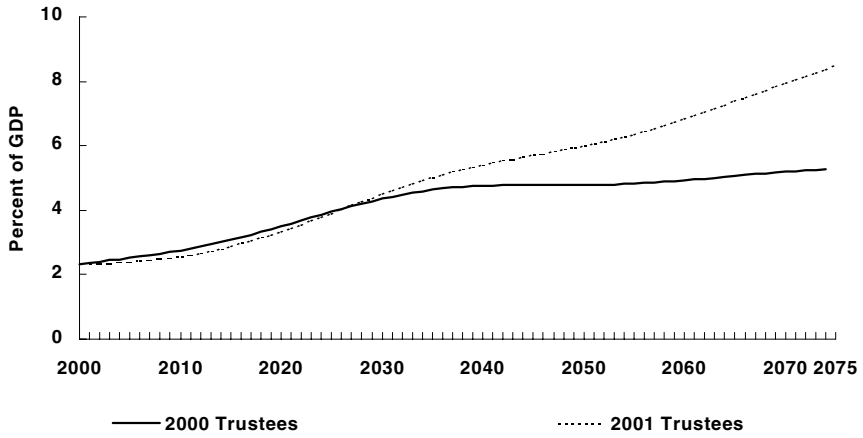
[3]Technical Review Panel on the Medicare Trustees Reports, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* (Dec. 2000). As the panel noted, for many years the Medicare projections have been based on an assumption that in the long run, average per-beneficiary costs would increase at about the same rate as program underlying funding sources. For HI, this meant that expenditures were assumed to increase at the same rate as average hourly earnings. For SMI, this meant that per-beneficiary costs were assumed to grow at the same rate as per-capita GDP.

[4]CBO, *The Long-Term Budget Outlook* (Oct. 2000).

[5]See *2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (March 2001) and *2001 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (March 2001).

dramatic implications of a 1-percentage point increase in annual Medicare spending over time. (See fig. 3)

Figure 3: Medicare Spending as a Share of GDP Under Old and New Assumptions



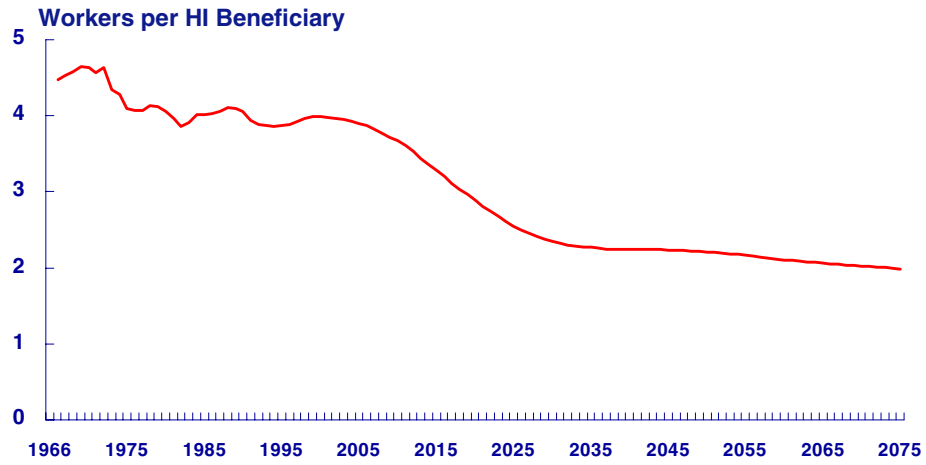
Note: Data are gross outlays as projected under the Trustees' intermediate assumptions.

Source: GAO analysis of data from the 2000 and 2001 HI and SMI Trustees Reports.

In part the progressive absorption of a greater share of the nation's resources for health care, as with Social Security, is a reflection of the rising share of the population that is elderly. Both programs face demographic conditions that require action now to avoid burdening future generations with the program's rising costs. Like Social Security, Medicare's financial condition is directly affected by the relative size of the populations of covered workers and beneficiaries. Historically, this relationship has been favorable. In the near future, however, the covered worker-to-retiree ratio will change in ways that threaten the financial solvency and sustainability of this important national program. In 1970 there were 4.6 workers per HI beneficiary. Today there are about 4, and in 2030, this ratio will decline to only 2.3 workers per HI beneficiary.[6] (See fig. 4.)

[6]For Social Security, there were 3.7 covered workers per beneficiary in 1970. Today there are 3.4, and the ratio is expected to decline to 2.1 in 2030.

Figure 4: Workers Per HI Beneficiary Expected to Decline



Source: GAO analysis of data from the Office of the Actuary, CMS.

Unlike Social Security, however, Medicare growth rates reflect not only a burgeoning beneficiary population, but also 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.[7] Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of health care decisions. All of these factors contribute to making Medicare a much greater and more complex fiscal challenge than even Social Security.

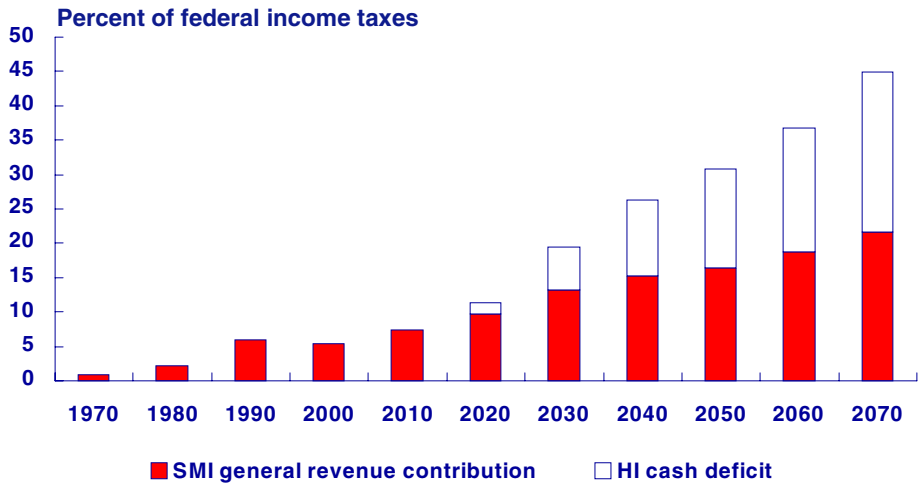
When viewed from the perspective of the federal budget and the economy, the growth in health care spending will become increasingly unsustainable over the longer term.[8] Figure 5 shows the sum of the future expected HI

[7]In arriving at their recommendation for Medicare long-term cost growth, the Medicare Technical Panel observed that historically, the primary long-run determinant of real health care spending has been the development and diffusion of new medical technology.

[8]See *Long-Term Budget Issues: Moving from Balancing the Budget to Balancing Fiscal Risk* (GAO-01-385T, Feb. 6, 2001).

cash deficit and the expected general fund contribution to SMI as a share of federal income taxes under the Trustees 2001 intermediate estimates. SMI has received contributions from the general fund since the inception of the program. This general revenue contribution is projected to grow from about 5 percent of federal personal and corporate income taxes in 2000 to 13 percent by 2030. Beginning in 2016, use of general fund revenues will be required to pay benefits as the HI trust fund redeems its Treasury securities. Assuming general fund revenues are used to pay benefits after the trust fund is exhausted, by 2030 the HI program alone would consume more than 6 percent of income tax revenue. On a combined basis, Medicare's draw on general revenues would grow from 5.4 percent of income taxes today to nearly 20 percent in 2030 and 45 percent by 2070.

Figure 5: SMI General Revenue Contribution and HI Cash Deficit as a Share of Federal Corporate and Personal Income Taxes



Note: Estimates are based on the Trustees' 2001 intermediate assumptions and assume that personal and corporate federal income taxes remain at the same share of gross domestic product as in 2000.

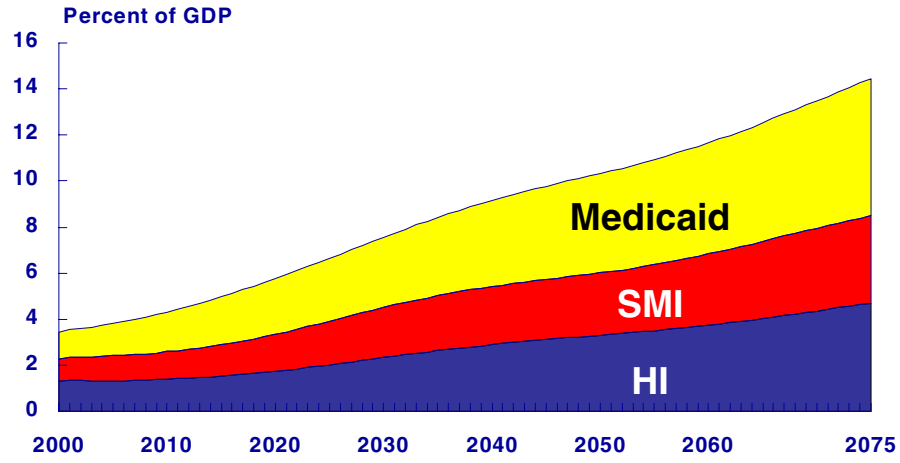
Source: GAO analysis of data from the Office of the Chief Actuary, CMS, 2001 intermediate assumptions.

Figure 6 reinforces the need to look beyond the HI program. HI is only the first layer in this figure. The middle layer adds the SMI program, which is expected to grow faster than HI in the near future. By the end of the 75-

year projection period, SMI will represent almost half of total estimated Medicare costs.

To get a more complete picture of the future federal health care entitlement burden, Medicaid is added. Medicare and the federal portion of Medicaid together will grow to 14.5 percent of GDP from today's 3.5 percent. Taken together, the two major government health programs—Medicare and Medicaid—represent an unsustainable burden on future generations. In addition, this figure does not reflect the taxpayer burden of state and local Medicaid expenditures. A recent statement by the National Governors Association argues that increased Medicaid spending has already made it difficult for states to increase funding for other priorities.

Figure 6: Medicare and Medicaid Spending as a Share of GDP



Notes:

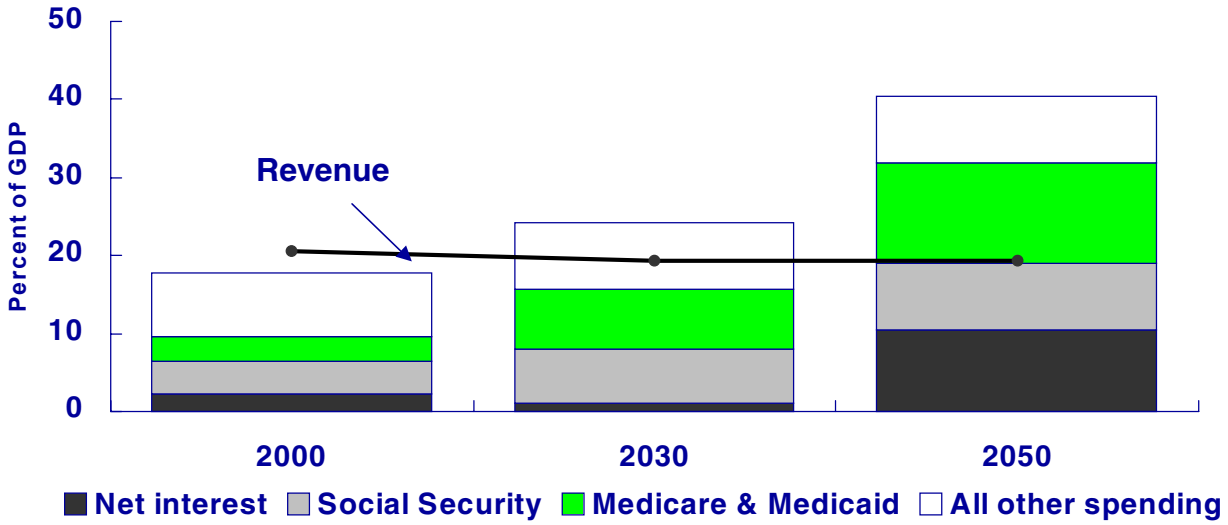
1. Medicare data are gross outlays as projected under the Trustees' 2001 intermediate assumptions.
2. Federal Medicaid data based on CBO's October 2000 long-term budget outlook.

Source: GAO analysis of data from the Congressional Budget Office and the March 2001 HI and SMI Trustees Reports.

Our long-term simulations show that to move into the future with no changes in federal health and retirement programs is to envision a very different role for the federal government. Assuming, for example, that Congress and the President adhere to the often-stated goal of saving the Social Security surpluses, our long-term simulations show a world by 2030 in which Social Security, Medicare, and Medicaid absorb most of the available revenues within the federal budget. Under this scenario, these

programs would require more than three-quarters of total federal revenue even without adding a Medicare prescription drug benefit. (See fig. 7.)

Figure 7: Composition of Federal Spending as a Share of GDP Under the "Save the Social Security Surpluses" Simulation



Notes:

Revenue as a share of GDP declines from its 2000 level of 20.6 percent due to unspecified permanent policy actions. In this display, policy changes are allocated equally between revenue reductions and spending increases.

The "Save the Social Security Surpluses" simulation can only be run through 2056 due to the elimination of the capital stock.

Source: GAO's March 2001 analysis.

This scenario contemplates saving surpluses for 20 years—an unprecedented period of surpluses in our history—and retiring publicly held debt. Alone, however, even saving all Social Security surpluses would not be enough to avoid encumbering the budget with unsustainable costs from these entitlement programs. Little room would be left for other federal spending priorities such as national defense, education, and law enforcement. Absent changes in the structure of Medicare and Social Security, sometime during the 2040s government would do nothing but mail checks to the elderly and their health care providers. Accordingly, substantive reform of the Medicare and Social Security programs remains critical to recapturing our future fiscal flexibility.

Demographics argue for early action to address Medicare's fiscal imbalances. Ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. In addition, timely action to bring costs down pays large fiscal dividends for the program and the budget. The high projected growth of Medicare in the coming years means that the earlier reform begins, the greater the savings will be as a result of the effects of compounding.

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. Today's decisions can have wide-ranging effects on our ability to afford tomorrow's commitments. As I have testified before, you can think of the budget choices you face as a portfolio of fiscal options balancing today's unmet needs with tomorrow's fiscal challenges. At the one end—with the lowest risk to the long-range fiscal position—is reducing publicly held debt. At the other end—offering the greatest risk—is increasing entitlement spending without fundamental program reform.

Reducing publicly held debt helps lift future fiscal burdens by freeing up budgetary resources encumbered for interest payments, which currently represent about 12 cents of every federal dollar spent, and by enhancing the pool of economic resources available for private investment and long-term economic growth. This is particularly crucial in view of the known fiscal pressures that will begin bearing down on future budgets in about 10 years as the baby boomers start to retire. However, as noted above, debt reduction is not enough. Our long-term simulations illustrate that, absent entitlement reform, large and persistent deficits will return.

Medicare's Bleak Financial Outlook Drives Need for Meaningful Program and Management Reform

Despite common agreement that, without reform, future program costs will consume growing shares of the federal budget, there is also a mounting consensus that Medicare's benefit package should be expanded to cover prescription drugs, which will add billions to the program's cost. This places added pressure on policymakers to consider proposals that could fundamentally reform Medicare. Our previous work provides, I believe, some considerations that are relevant to deliberations regarding the potential addition of a prescription drug benefit and Medicare reform options that would inject competitive mechanisms to help control costs. In addition, our reviews of HCFA offer lessons for improving Medicare's management. Implementing necessary reforms that address Medicare's financial imbalance and meet the needs of beneficiaries will not be easy.

We must have a Medicare agency that is ready and able to meet these 21st century challenges.

Adding a Fiscally Responsible Prescription Drug Benefit Will Entail Multiple Trade-Offs

Among the major policy challenges facing the Congress today is how to reconcile Medicare's unsustainable long-range financial condition with the growing demand for an expensive new benefit—namely, coverage for prescription drugs. It is a given that prescription drugs play a far greater role in health care now than when Medicare was created. Today, Medicare beneficiaries tend to need and use more drugs than other Americans. However, because adding a benefit of such potential magnitude could further erode the program's already unsustainable financial condition, you face difficult choices about design and implementation options that will have a significant impact on beneficiaries, the program, and the marketplace.

Let's examine the current status regarding Medicare beneficiaries and drug coverage. About a third of Medicare beneficiaries have no coverage for prescription drugs. Some beneficiaries with the lowest incomes receive coverage through Medicaid. Some beneficiaries receive drug coverage through former employers, some can join Medicare+Choice plans that offer drug benefits, and some have supplemental Medigap coverage that pays for drugs. However, significant gaps remain. For example, Medicare+Choice plans offering drug benefits are not available everywhere and generally do not provide catastrophic coverage. Medigap plans are expensive and have caps that significantly constrain the protection they offer. Thus, beneficiaries with modest incomes and high drug expenditures are most vulnerable to these coverage gaps.

Overall, the nation's spending on prescription drugs has been increasing about twice as fast as spending on other health care services, and it is expected to keep growing. Recent estimates show that national per-person spending for prescription drugs will increase at an average annual rate exceeding 10 percent until at least 2010. As the cost of drug coverage has been increasing, employers and Medicare+Choice plans have been cutting back on prescription drug benefits by raising enrollees' cost-sharing, charging higher copayments for more expensive drugs, or eliminating the benefit altogether.

It is not news that adding a prescription drug benefit to Medicare will be costly. However, the cost consequences of a Medicare drug benefit will depend on choices made about its design—including the benefit's scope and financing mechanism. For instance, a Medicare prescription drug

benefit could be designed to provide coverage for all beneficiaries, coverage only for beneficiaries with extraordinary drug expenses, coverage only for low-income beneficiaries. Policymakers would need to determine how costs would be shared between taxpayers and beneficiaries through premiums, deductibles, and copayments and whether subsidies would be available to low-income, non-Medicaid eligible individuals. Design decisions would also affect the extent to which a new pharmaceutical benefit might shift to Medicare portions of the out-of-pocket costs now borne by beneficiaries as well as those costs now paid by Medicaid, Medigap, or employer plans covering prescription drugs for retirees. Clearly, the details of a prescription drug benefit's implementation would have a significant impact on both beneficiaries and program spending. Experience suggests that some combination of enhanced access to discounted prices, targeted subsidies, and measures to make beneficiaries more aware of costs may be needed. Any option would need to balance concerns about Medicare sustainability with the need to address what will likely be a growing hardship for some beneficiaries in obtaining prescription drugs.

Reform Options Based on Competition Offer Advantages but Contain Limitations

The financial prognosis for Medicare clearly calls for meaningful spending reforms to help ensure that the program is sustainable over the long haul. The importance of such reforms will be heightened if financial pressures on Medicare are increased by the addition of new benefits, such as coverage for prescription drugs. Some leading reform proposals envision that Medicare could achieve savings by adapting some of the competitive elements embodied in the Federal Employees Health Benefits Program. Specifically, these proposals would move Medicare towards a model in which health plans compete on the basis of benefits offered and costs to the government and beneficiaries, making the price of health care more transparent.

Currently, Medicare follows a complex formula to set payment rates for Medicare+Choice plans, and plans compete primarily on the richness of their benefit packages. Medicare permits plans to earn a reasonable profit, equal to the amount they can earn from a commercial contract. Efficient plans that keep costs below the fixed payment amount can use the "savings" to enhance their benefit packages, thus attracting additional members and gaining market share. Under this arrangement, competition

among Medicare plans may produce advantages for beneficiaries, but the government reaps no savings.[9]

In contrast, a competitive premium approach offers certain advantages. Instead of having the government administratively set a payment amount and letting plans decide—subject to some minimum requirements—the benefits they will offer, plans would set their own premiums and offer at least a required minimum Medicare benefit package. Under these proposals, Medicare costs would be more transparent: beneficiaries could better see what they and the government were paying for in connection with health care expenditures. Beneficiaries would generally pay a portion of the premium and Medicare would pay the rest. Plans operating at lower cost could reduce premiums, attract beneficiaries, and increase market share. Beneficiaries who joined these plans would enjoy lower out-of-pocket expenses. Unlike today's Medicare+Choice program, the competitive premium approach provides the potential for taxpayers to benefit from the competitive forces. As beneficiaries migrated to lower-cost plans, the average government payment would fall.

Experience with the Medicare+Choice program reminds us that competition in Medicare has its limits. First, not all geographic areas are able to support multiple health plans. Medicare health plans historically have had difficulty operating efficiently in rural areas because of a sparseness of both beneficiaries and providers. In 2000, 21 percent of rural beneficiaries had access to a Medicare+Choice plan, compared to 97 percent of urban beneficiaries. Second, separating winners from losers is a basic function of competition. Thus, under a competitive premium approach, not all plans would thrive, requiring that provisions be made to protect beneficiaries enrolled in less successful plans.

Effective Program Management Key to Successful Reform Efforts

The extraordinary challenge of developing and implementing Medicare reforms should not be underestimated. Our look at health care spending projections shows that, with respect to Medicare reform, small implementation problems can have huge consequences. To be effective, a good program design will need to be coupled with competent program

[9]In fact, the government has been losing money on the Medicare+Choice program. Medicare pays more, on average, for beneficiaries enrolled in managed care plans than if these individuals had remained in traditional Medicare. See *Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending* (GAO/HEHS-00-161, Aug. 23, 2000).

management. Consistent with that view, questions are being raised about the ability of CMS to administer the Medicare program effectively.

Our reviews of Medicare program activities confirm the legitimacy of these concerns. In our companion statement today, we discuss not only the Medicare agency's performance record but also areas where constraints have limited the agency's achievements. We also identify challenges the agency faces in seeking to meet expectations for the future.

As the Congress and the Administration focus on current Medicare management issues, our review of HCFA suggests several lessons:

- Managing for results is fundamental to an agency's ability to set meaningful goals for performance, measure performance against those goals, and hold managers accountable for their results. Our work shows that HCFA has faltered in adopting a results-based approach to agency management, leaving the agency in a weakened position for assuming upcoming responsibilities. In some instances, the agency may not have the tools it needs because it has not been given explicit statutory authority. For example, the agency has sought explicit statutory authority to use full and open competition to select claims administration contractors. The agency believes that without such statutory authority it is at a disadvantage in selecting the best performers to carry out Medicare claims administration and customer service functions. To be effective, any agency must be equipped with the full complement of management tools it needs to get the job done.
- A high-performance organization demands a workforce with, among other things, up-to-date skills to enhance the agency's value to its customers and ensure that it is equipped to achieve its mission. HCFA began workforce planning efforts that continue today in an effort to identify areas in which staff skills are not well matched to the agency's evolving mission. In addition, CMS recently reorganized its structure to be more responsive to its customers. It is important that CMS continue to reevaluate its skill needs and organizational structure as new demands are placed on the agency.
- Data-driven information is essential to assess the budgetary impact of policy changes and distinguish between desirable and undesirable consequences. Ideally, the agency that runs Medicare should have the ability to monitor the effects of Medicare reforms, if enacted—such as adding a drug benefit or reshaping the program's design. However, HCFA was unable to make timely assessments, largely because its information systems were not up to the task. The status of these systems remains the same, leaving CMS unprepared to determine, within reasonable time

frames, the appropriateness of services provided and program expenditures. The need for timely, accurate, and useful information is particularly important in a program where small rate changes developed from faulty estimates can mean billions of dollars in overpayments or underpayments.

- An agency's capacity should be commensurate with its responsibilities. As the Congress continues to modify Medicare, CMS' responsibilities will grow substantially. HCFA's tasks increased enormously with the enactment of landmark Medicare legislation in 1997 and the modifications to that legislation in 1999 and 2000. In addition to the growth in Medicare responsibilities, the agency that administers this program is also responsible for other large health insurance programs and activities. As the agency's mission has grown, however, its administrative dollars have been stretched thinner. Adequate resources are vital to support the kind of oversight and stewardship activities that Americans have come to count on—inspection of nursing homes and laboratories, certification of Medicare providers, collection and analysis of critical health care data, to name a few. Shortchanging this agency's administrative budget will put the agency's ability to handle upcoming reforms at serious risk.

In short, because Medicare's future will play such a significant role in the future of the American economy, we cannot afford to settle for anything less than a world-class organization to run the program. However, achieving such a goal will require a clear recognition of the fundamental importance of efficient and effective day-to-day operations.

Conclusions

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. I feel that the greatest risk lies in doing nothing to improve the Medicare program's long-term sustainability. It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Engaging in a comprehensive effort to reform the Medicare program and put it on a sustainable path for the future would help fulfill this generation's stewardship responsibility to succeeding generations. It would also help to preserve some capacity for future generations to make their own choices for what role they want the federal government to play.

Updating Medicare's benefit package may be a necessary part of any realistic reform program. Such changes, however, need to be considered in the context of Medicare's long-term fiscal outlook and the need to make changes in ways that will promote the program's longer-term

sustainability. We must remember that benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. The BBA experience reminds us about the difficulty of undertaking reform.

Most importantly, any substantial benefit reform should be coupled with other meaningful program reforms that will help to ensure the long-term sustainability of the program. In the end, the Congress should consider adopting a Hippocratic oath for Medicare reform proposals—namely, "Don't make the long-term outlook worse." Ultimately, we will need to engage in a much more fundamental health care reform debate to differentiate wants, which are virtually unlimited, from needs, which should be defined and addressed, and overall affordability, of which there is a limit.

We at GAO look forward to continuing to work with this Committee and the Congress in addressing this and other important issues facing our nation. In doing so, we will be true to our core values of accountability, integrity, and reliability.

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

(290101)