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MEDICARE REFORM

Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead

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Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss Medicare reform. I would like to focus my remarks on the two leading proposals that involve more comprehensive reform—that is, reform that addresses cost containment as well as expanded benefits. However, before examining these proposals, I would like to speak again about a budgetary context for understanding the proposed reforms in light of Medicare' s future sustainability and the long-range budget outlook.

I spoke with you twice last year about this topic, and despite some very positive, short-term developments regarding our economy, the federal surplus, and Medicare spending, the bigger picture remains virtually unchanged. Long-term cost pressures facing the Medicare program are considerable. Even before adding a prescription drug benefit, for example, projected program spending threatens to absorb ever-increasing shares of the nation's budgetary and economic resources.

It is tempting to push aside this gloomy forecast in the face of today's sunny budget report. In its most recent projections, the Congressional Budget Office (CBO) shows both unified and on-budget surpluses throughout the next 10 years. However, good news does not mean that hard choices are a thing of the past. First, it is important to recognize that, by their very nature, projections are uncertain. This is especially true today because, as CBO notes, it is too soon to tell whether recent boosts in revenue reflect a major structural change in the economy or a more temporary divergence from historical trends. Indeed, CBO points out that assuming a return to historical trends and slightly faster growth in Medicare would change the on-budget surplus to a growing deficit. This means we should treat surplus predictions with caution. Because current projected surpluses could prove to be fleeting, appropriate steps should be taken if new entitlements are created that establish permanent claims on future resources.

Moreover, while the size of future surpluses could exceed or fall short of projections, we know that demographic and cost trends will, in the 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 begin addressing the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and possible solutions much more painful.

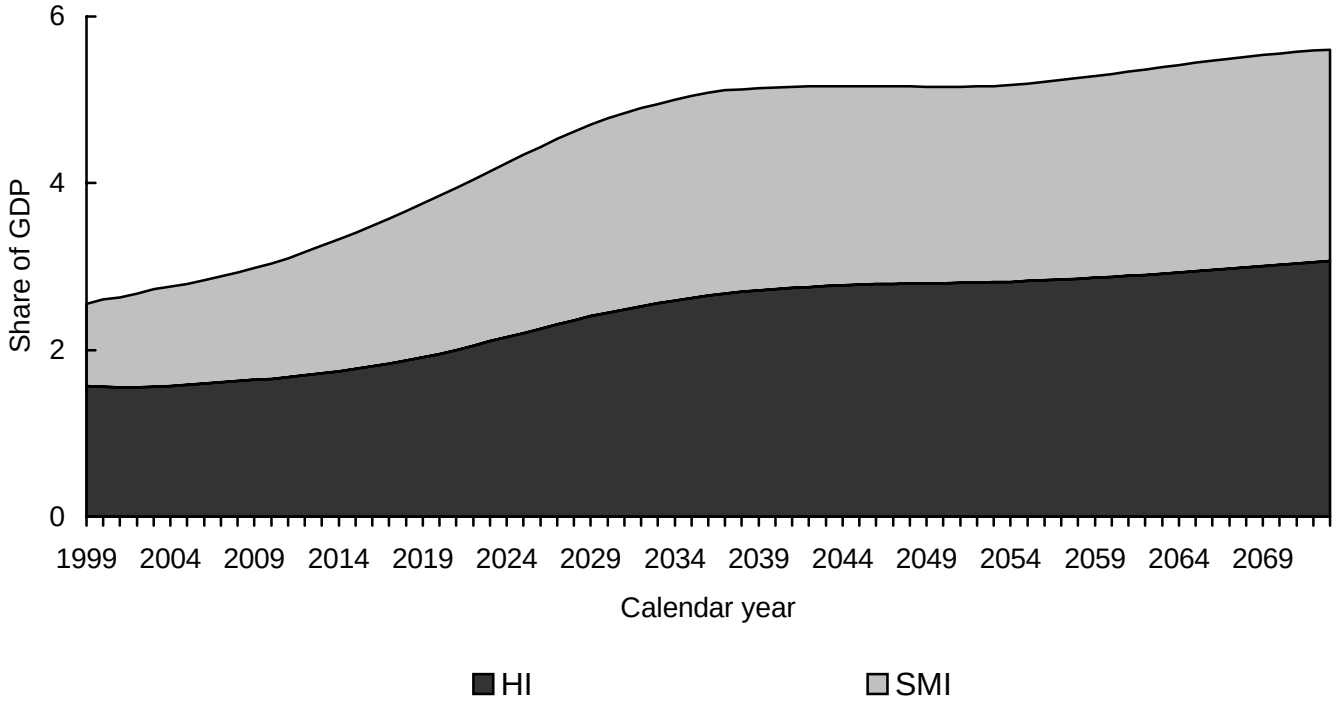
It is in this context that we are discussing Medicare reform today. Among various proposals, the two I will focus on are the President's Plan to Modernize and Strengthen Medicare for the 21st Century and S. 1895, entitled the Medicare Preservation and Improvement Act of 1999, which is commonly referred to as the Breaux-Frist proposal. By including a more comprehensive reform, the intent of these proposals would be consistent with the position we have maintained from the beginning of these deliberations; namely, that 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. Such additions 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, a reform package should include a mechanism to monitor aggregate program costs over time and establish expenditure or funding thresholds that would trigger a call for fiscal action.

As we consider key elements of these two proposals, I would ask you to keep in mind the following: these two plans reflect considerable efforts by the Administration and the Congress to wrestle with the twin problems of program adequacy and sustainability. However, unlike the game show, "Who Wants To Be A Millionaire," comprehensive reform does not come with a "final answer." Nor is it something that, once implemented, can be put on automatic pilot. Recent experience implementing changes to the current program shows that reform is a dynamic process requiring vigilance, flexibility, and endurance. We must be able to monitor the impact of reform, make changes when actual outcomes differ substantially from the expected ones, and remain steadfast when particular interests pit the primacy of their wants against the more global interest of making Medicare affordable, sustainable, and effective for current and future generations of Americans.

Medicare's Financial Condition

Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) expenditures are expected to increase dramatically, rising from about 12 percent in 1999 to about a quarter of all federal revenues by mid-century, even without adding to the benefit package. 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 in figure 1.

Figure 1: Medicare Spending as a Percentage of Gross Domestic Product (GDP) 1999 to 2073



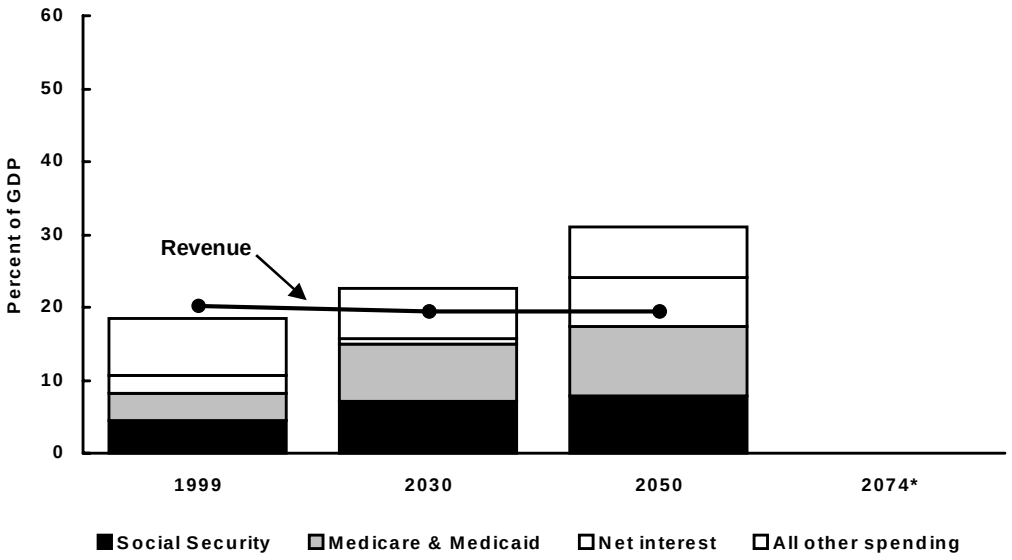
Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

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 the elderly population, but 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 health 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. Assuming, for example, that the Congress and the President adhere to the often-stated goal of saving the Social Security surpluses, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. Under this scenario, these programs would require more than three-quarters of total federal revenue. (See fig. 2.) Budgetary flexibility would be drastically constrained and little room would be left for programs for national defense, the young, infrastructure, and law enforcement.

Figure 2: Composition of Spending as a Share of GDP Under "Eliminate Non-Social Security Surpluses" Simulation



*The "Eliminate non-Social Security surpluses" simulation can only be run through 2066 due to the elimination of the capital stock.

Notes:

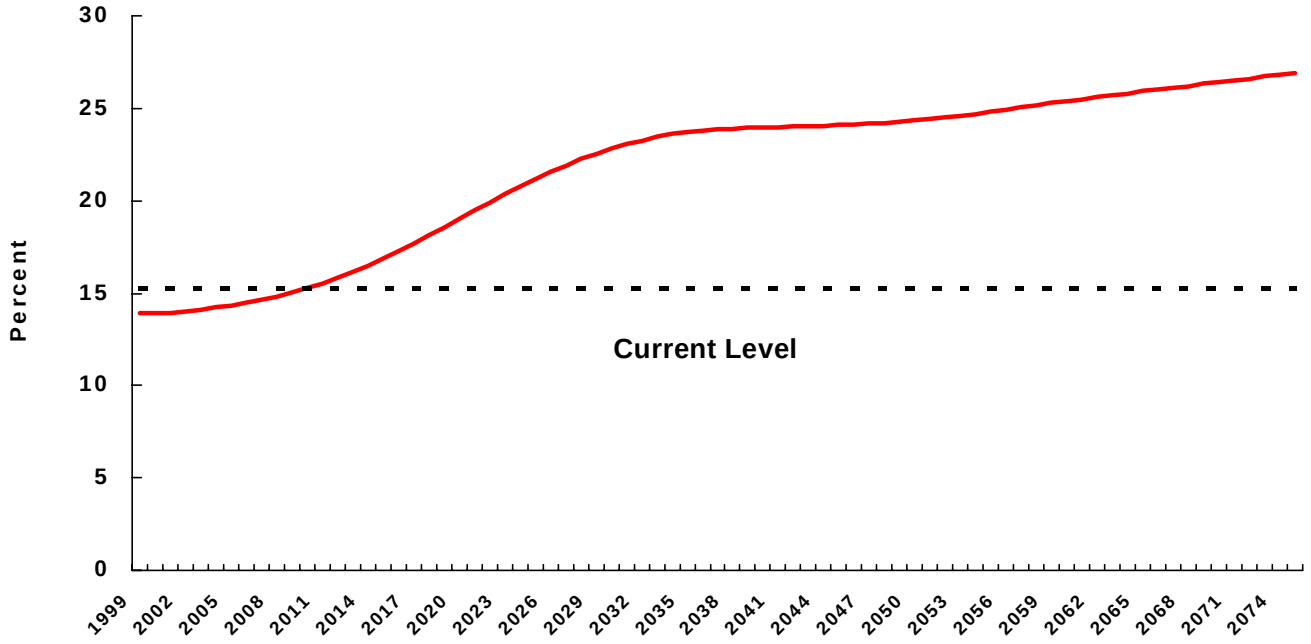
Revenue as a share of GDP during the simulation period is lower than the 1999 level due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.

Medicare expenditure projections follow the Trustees' 1999 intermediate assumptions. The projections reflect the current benefit and financing structure.

Source: GAO's January 2000 analysis.

When viewed together with Social Security, the financial burden of Medicare on future taxpayers becomes unsustainable, absent reform. As figure 3 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 3: Social Security and Medicare HI as a Percentage of Taxable Payroll, 1999 to 2074



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund, and *1999 Annual Report*, Board of Trustees of the Federal Old Age and Survivors Disability Insurance Trust Funds.

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 HI trust fund. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

Today's Medicare Program

The elements of restructuring of Medicare as proposed by the President and Breaux-Frist are best understood in light of Medicare's current structure. From the perspective of the program's benefit package, most beneficiaries have two broad choices: they can receive health care coverage through Medicare's traditional fee-for-service program or

through its managed care component, called Medicare+Choice. The latter consists of an array of private health plans whose availability to Medicare beneficiaries varies by county across the nation.

Differences Between Traditional Medicare and Medicare+Choice

The choice between traditional Medicare and a Medicare+Choice plan typically involves certain trade-offs related to selection of providers, services covered, and out-of-pocket costs. Another key difference pertains to program payment methods.

- *Provider choice.* Under traditional Medicare, beneficiaries may obtain covered services from any physician, hospital, or other health care provider that receives Medicare payments. Because most providers accept Medicare payments, beneficiaries have virtually unlimited choice. In contrast, beneficiaries in managed care face a more restricted list of providers. Private plan enrollees can generally use only their plan's network of doctors, hospitals, or other providers for nonemergency care.

- *Services offered.* Although offering less provider choice, Medicare+Choice plans typically cover more services. For example, Medicare+Choice plans often cover routine physicals, outpatient prescription drugs, and dental care—services that traditional Medicare does not cover.

- *Out-of-pocket costs.* Out-of-pocket costs are generally higher for beneficiaries in traditional Medicare than for those in Medicare+Choice. Traditional Medicare, which has a two-part benefit package, does not pay the full costs of most covered services. Part A has no premium and helps pay for hospitalization, skilled nursing facility care, some home health care, and hospice care. Part B, which is optional in traditional Medicare, requires a monthly premium ($45.50) and helps pay for physician services, clinical laboratory services, hospital outpatient care, and certain other medical services. In addition to the monthly premium, beneficiaries are responsible for an annual $100-deductible and for 20 percent of the Medicare-approved amount for most part B services. To cover these out-of-pocket expenses, many beneficiaries purchase private supplemental insurance, known as Medigap, or may have similar insurance through a former employer.

- In contrast, beneficiaries covered through a Medicare+Choice plan are required to pay part B premiums but often do not pay the plan a monthly premium or pay a monthly fee that is less than the cost of an equivalent Medigap policy. Plan enrollees may also pay a copayment for each visit or service.

- *Program payments.* Another key difference between traditional Medicare and Medicare+Choice involves the program's payment methods. In traditional Medicare, hospitals, physicians, and other providers receive a separate payment for each covered medical service or course of treatment provided. In contrast, Medicare+Choice plans receive a fixed monthly amount for each beneficiary they enroll, commonly known as a capitation payment. This amount covers the expected costs of all Medicare part A and part B services. If Medicare's payment is projected to result in a plan's earning above normal profits—that is, above the rate of return earned on its commercial contracts—the plan generally must use the excess to fund additional benefits.

Overspending on Medicare+Choice

If the extra benefits—such as prescription drugs and lower cost-sharing—provided by Medicare+Choice plans resulted exclusively from efficiencies achieved by the plans, there would be no cause for taxpayers to be concerned. However, evidence shows that, because of flaws in Medicare's methodology for computing payments, payments to plans are too high and plans turn these excess payments into extra benefits to attract beneficiaries. Instead of producing program savings as originally envisioned, Medicare's managed care option has added substantially to program spending.

Nevertheless, as we reported last year, program savings and extra benefits for Medicare beneficiaries are not mutually exclusive goals.[1] According to their own data, many plans could make a normal profit and provide enhanced benefit packages, even if Medicare payments were reduced. However, to lower program spending would require a better method of adjusting plan payments for differences in the health status of beneficiaries, a process commonly known as risk adjustment. Medicare's current risk adjustment methodology cannot adequately account for the fact that, on average, beneficiaries in Medicare+Choice are healthier than those in traditional Medicare.[2]

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

[2] *Payments to Medicare+Choice plans are based on the estimated cost of serving the average beneficiary in traditional Medicare. The methodology to adjust these payments for better or worse-than-average health status is based on simple demographic characteristics, such as age and sex. These are not adequate adjusters: two beneficiaries can be demographically identical (same age and sex), but one may experience occasional minor ailments while the other suffers from a serious chronic condition. Without the use of health status factors to account for that distinction, Medicare's risk adjuster produces excessive payments in compensating plans for their relatively lower cost enrollees.*

Issues Related to Prescription Drug Benefit

Extensive research and development over the past 10 years have led to new prescription drug therapies and improvements over existing therapies. In some instances, new medications have expanded the array of conditions and diseases that can be treated effectively. In other cases, they have replaced alternative health care interventions. For example, new medications for the treatment of ulcers have virtually eliminated the need for some surgical treatments. As a result of these innovations, the importance of prescription drugs as part of health care has grown. However, new drug therapies have also contributed to a significant increase in drug spending as a component of health care costs. The Medicare benefit package, largely designed in 1965, provides virtually no coverage. This does not mean, however, that all Medicare beneficiaries lack coverage for prescription drug costs. In 1996, almost one third of beneficiaries had employer-sponsored health coverage, as retirees, that included drug benefits. More than 10 percent of beneficiaries received coverage through Medicaid or other public programs. To protect against drug costs, the remainder of Medicare beneficiaries can choose to enroll in a Medicare+Choice plan with drug coverage if one is available in their area or purchase a Medigap policy.

The burden of prescription drug costs falls most heavily on the Medicare beneficiaries who lack drug coverage or who have substantial health care needs. Drug coverage is less prevalent among beneficiaries with lower incomes. In 1995, 38 percent of beneficiaries with income below $20,000 were without drug coverage, compared to 30 percent of beneficiaries with higher incomes. Additionally, the 1995 data show that drug coverage is slightly higher among those with poorer self-reported health status. At the same time, however, beneficiaries without drug coverage and in poor health had drug expenditures that were $400 lower than the expenditures of beneficiaries with drug coverage and in poor health. This might indicate access problems for this segment of the population.

Even for beneficiaries who have drug coverage, the extent of the protection it affords varies, and there are signs that this coverage could be eroding. The value of a beneficiary's drug benefit is affected by the benefit design, including cost-sharing requirements and benefit limitations. Although reasonable cost sharing serves to make the consumer a more prudent purchaser, copayments, deductibles, and annual coverage limits can reduce the value of drug coverage to the beneficiary. Recent trends of declining employer coverage and more stringent Medicare+Choice benefit limits suggest that the proportion of beneficiaries without effective protection may grow.

Expanding access to more affordable prescription drugs could involve either subsidizing prescription drug coverage or allowing beneficiaries access to discounted pharmaceutical prices. The design of a drug coverage option, that is, the scope of the benefit, the targeted population, and the mechanisms used to contain costs, as well as its implementation, will determine the option's effect on beneficiaries, Medicare or federal spending, and the pharmaceutical market. Any option would need to consider how to balance competing concerns about the sustainability of Medicare, federal obligations, and the hardship faced by some beneficiaries.

President's Plan and Breaux-Frist Proposal: Two Versions of Competitive Premium Approach

the President's Plan And The Breaux-Frist Proposal Are Similar In Three Key Areas But Contain Two Major Differences. To Varying Degrees, Both Proposals

- introduce a competitive premium model, similar in concept to the Federal Employees Health Benefit Program (FEHBP), to achieve cost efficiencies;
- preserve the traditional fee-for-service Medicare program with enhanced opportunities to adopt prudent purchasing strategies; and
- modernize Medicare's benefit package by making coverage available for prescription drug and catastrophic Medicare costs.

The proposals differ, however, in the extent to which traditional Medicare could face competitive pressure from private plans. In addition, under the President's plan, the Health Care Financing Administration (HCFA) would administer the program, whereas under the Breaux-Frist proposal, an independent Medicare board would perform that function.

An elaboration of these points helps explain where the two proposals share common ground and where they diverge.

Competitive Model for Setting Premiums

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. Efficient plans that reduce costs below the fixed payment amount can use the "savings" to enhance their benefit packages, thus attracting additional members and gaining market share. Although

competition among Medicare plans may produce advantages for beneficiaries, the government reaps no savings.[3]

In contrast, the competitive premium approach included in the Breaux-Frist and President's proposals offers certain advantages. Under either version, beneficiaries can better see what they and the government are paying for. In addition, plans that can reduce costs can lower premiums and attract more enrollees. As the more efficient plans gain market share, the government's spending on Medicare will decrease.

Fundamentally, this approach is intended to spur price competition. Instead of administratively setting 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 a common Medicare benefit package. Under both proposals, beneficiaries would generally pay a small portion of the premium and the government would pay the rest. Plans that operate at lower cost could reduce premiums, attract beneficiaries, and increase market share. Beneficiaries who joined these plans would enjoy lower out-of-pocket expenses. Taxpayers, however, would also benefit from the competitive forces. As beneficiaries migrated to lower cost plans, the average government payment would fall. (See table 1.)

[3]Beneficiaries who enroll in plans with low costs enjoy coverage for additional benefits, including reduced cost-sharing. Regardless of private plan selected, however, plan enrollees must continue to pay part B premiums.

Table 1: Under Both Versions of Competitive Approach, Medicare and Beneficiaries Can Enjoy Direct Savings

	Medicare+Choice	President	Breaux-Frist
Payment rates	Administratively determined, largely based on fee-for-service (FFS) costs	Plans determine own premium for providing Medicare-covered benefits	Plans determine own premium for providing benefits
Maximum government contribution	About 89% of administratively determined payment rate[a]	- For private plans, 85% of traditional Medicare cost[b] - For traditional Medicare, about 89% of cost	88% of national average premium, includes HCFA-sponsored FFS plan[c]
Beneficiary contribution	- Monthly part B premium to Medicare - May pay additional premium to plan	- Difference between private plan premium and government contribution - Nothing for private plans with premiums below about 80% of FFS cost - If in traditional FFS, approximately 11% of per capita program cost	- Difference between plan premium and government contribution - Nothing for plans with premiums at or below 85% of national average
Impact on beneficiary if enrolled in plan with relatively high costs	- Pay monthly part B premium to Medicare - Pay premium to plan	- Pay premium	- Pay premium
Impact on beneficiary if enrolled in plan with relatively low costs	Pay monthly part B premium to Medicare Pay little or no premium to plan Receive extra benefits	- Pay little or no premium	- Pay little or no premium
Impact on Medicare if beneficiary enrolled in plan with costs below maximum government contribution	None; savings flow to plan and beneficiaries	Receives portion of savings	Receives portion of savings

[a]Net effect, government payments offset by beneficiary part B premiums (assumed to total about 11 percent of FFS costs).

[b]Net effect, maximum government payment set at 96 percent of average FFS cost offset by beneficiary part B premiums revenue (assumed to equal about 11 percent of FFS costs).

[c]Plans submit premium for benefit package that may include benefits not covered by Medicare. Medicare Board determines the portion of the premium associated with Medicare-covered benefits and uses that amount to compute the enrollment-weighted national average.

One major difference between the two proposals concerns how the beneficiary premium would be set for those who remained in the traditional fee-for-service program. Under Breaux-Frist, there would be no separate part B premium. All plans—including traditional Medicare—would calculate a total premium expected to cover the cost of providing

Medicare-covered services to the average beneficiary. The maximum government contribution would be based on a formula. Beneficiaries would pay no premiums if they chose plans costing 85 percent or less than the national enrollment-weighted average premium. For plans with higher premiums, beneficiaries would pay an increasing portion of the premium. The traditional fee-for-service Medicare program would be regarded as one more plan. The monthly amount beneficiaries would pay to enroll in it, therefore, would depend on how expensive it was relative to the private plans.

In contrast, under the President's proposal, the beneficiary premium for traditional Medicare—the part B premium—would continue to be set administratively. As under Breaux-Frist, all other plans would submit competitive premiums. The maximum government contribution to private plans would be set at 96 percent of the average spending per-beneficiary in traditional Medicare. Beneficiaries who joined plans that cost less than that amount would pay reduced, or no, part B premiums. Beneficiaries who joined more expensive plans would pay higher part B premiums.

Some believe the design of the President's proposal would tend to insulate the traditional fee-for-service program, and those beneficiaries that remain in it, from market forces. At least in the short run, however, the practical differences between the President's proposal and the Breaux-Frist proposal may be small. Because the vast majority of beneficiaries are enrolled in the traditional fee-for-service program, the national average premium under Breaux-Frist would, in all likelihood, largely reflect the cost of traditional Medicare.

Table 2 presents a hypothetical example to illustrate how similar beneficiary and government contributions would be under Breaux-Frist and the President's proposal. It assumes private plans could provide Medicare-covered benefits for 90 percent of the cost incurred in the traditional fee-for-service program and that they enroll 17 percent of all beneficiaries (the percentage of beneficiaries currently enrolled in private plans).[4] In this example, beneficiaries in private plans would pay slightly less under the Breaux-Frist proposal compared to their contribution under the President's proposal. Beneficiaries in the traditional program would pay slightly more under Breaux-Frist.

[4]The 90-percent figure is used for illustrative purposes only and does not represent an estimate of private plan premiums. However, there is some evidence that some plans could submit premiums below fee for service costs. Before 1998, Medicare set plan payments at 95 percent of average fee-for-service spending. This discounted payment exceeded many plans' costs of providing Medicare benefits and suggests that some plans may be able to set premiums substantially below the average cost in the traditional program.

Table 2: Simulation Showing Similarities Between Two Proposals in Monthly Premium Contribution Amounts

			President's Proposal		Breaux-Frist Proposal	
	Total per capita premium	Beneficiaries enrolled	Beneficiary contribution	Government contribution	Beneficiary contribution	Government contribution
Private plans	$450[a]	17%	$33 (7.2%)	$418 (92.8%)	$26 (5.7%)	$424 (94.3%)
Traditional FFS	$500	83%	$55 (11.0%)	$445 (89.0%)	$67 (13.5%)	$433 (86.5%)
Overall average			$51 (10.3%)	$440 (89.7%)	$60 (12.2%)	$431 (87.8%)

[a]Private plan premium is a hypothetical example that assumes plans could provide Medicare-covered benefits for 90 percent of the costs incurred by the fee-for-service program.

Source: GAO analysis.

Over the longer term, larger differences will emerge only if private plans decide to compete aggressively on the basis of price for market share or traditional fee-for-service Medicare becomes significantly less able to control the growth of costs relative to private plans. Although the premium support proposals are intended to slow health care spending through competition, it is not certain that this will occur. Private plans may very well find that their most profitable strategy is to "shadow price" (set prices only slightly under) traditional Medicare and be satisfied with smaller market share. (Paradoxically, serving larger numbers of beneficiaries could lead to higher costs and less profit.)

The greater ability of private plans to control cost growth and thereby offer significantly lower premiums is not a foregone conclusion. Medicare's fee-for-service cost containment record over the longer term has not differed substantially from that of the private sector. In some periods, Medicare's cost growth has been lower; in others, higher. Today, actually, we are witnessing a resurgence of cost growth in private plans, while Medicare spending projections have flattened.

Prudent Purchasing Strategies for Traditional Medicare

More than 80 percent of Medicare beneficiaries currently receive their health care coverage through the traditional fee-for-service program. Both leading reform proposals recognize the importance of this program to beneficiaries and would ensure its continued availability nationwide. They also recognize that controlling the growth of overall Medicare spending requires a more efficient traditional program. Consequently, both proposals seek to make Medicare a more prudent purchaser of health care by introducing modern cost control strategies.

The President's proposal outlines several new approaches to controlling costs. It would, for example, allow the Secretary of Health and Human Services to contract with preferred provider organizations (PPO), negotiate discounted payment rates for specific services, and develop systems to manage the care (in a fee-for-service setting) of certain diseases or beneficiaries. The proposal would also adjust payments to providers and change beneficiary cost sharing requirements. Adopting these changes will entail considerable challenges given the sheer size of the Medicare program, its complexity, and the need for transparent policies in a public program. Moreover, how much the changes would save is uncertain and likely depends on how, and to what extent, these measures are implemented. For example, without supplemental insurance reform, a PPO option may not attract many beneficiaries because a majority have first-dollar coverage through supplemental policies and thus are insensitive to provider charges. Furthermore, cuts in provider payments are certain to meet with fierce opposition.

The Breaux-Frist proposal provides a vehicle to reform traditional Medicare, but does not suggest specific cost control devices. The proposal calls for HCFA to prepare an annual business plan, which would outline intended payment and management strategies, describe partnership arrangements with entities to provide prescription drug benefits, and recommend benefit improvements. It would also include any legislative specifications necessary to enact the plan. Until 2008, HCFA would need explicit congressional approval to implement its business plan. After that, the plan would take effect without Congress' explicit approval. Clearly, the Breaux-Frist proposal could increase HCFA's options for managing the traditional program and controlling spending. Like the President's proposal, however, the extent of its success will depend on the specific details and other reform elements that HCFA designs and the Congress allows to be adopted.

Coverage for Prescription Drug and Catastrophic Costs

The leading proposals include provisions for two commonly discussed benefit expansions: an outpatient prescription drug benefit and coverage for extraordinary out-of-pocket expenses, known as catastrophic or stop-loss coverage. In this regard, Breaux-Frist and the President's proposal share many similarities. (See table 3.) Under both proposals the coverage is voluntary, although income-targeted subsidies are provided to encourage the purchase of prescription drug coverage. By making the drug benefit financially attractive, the proposals seek to maximize participation and avoid "adverse selection" problems—that is, having only high- cost beneficiaries purchase coverage and driving up premium costs. Low-income beneficiaries would pay nothing for the drug benefit, while those

earning more would pay up to 75 percent of the cost. To further minimize adverse selection problems, the President's proposal includes, and Breaux-Frist considers, a provision limiting opportunities to select drug coverage.

Table 3: Prescription Drug And Stop-Loss Coverage.

President	Breaux-Frist
Drug benefit available through new part D program.	Drug benefit available through high-option plans.
Drug coverage up to $1,000 per year in 2003, rising to $2,500 in 2009.	Drug coverage with an actuarial value of $800 per year in 2003, to be increased annually.[a]
Medicare subsidizes between 25% and 100% of drug benefit cost based on beneficiary income.	Medicare subsidizes between 25% and 100% of drug benefit cost based on beneficiary income.
Incentives for employers to retain retiree drug coverage.	No incentives specified.
Stop-loss for non-drug Medicare expenses available through new Medigap policy. Reserve fund for a future catastrophic drug benefit.	Stop-loss for non-drug Medicare expenses over $2,000 per year available through optional high option plans.

[a]Because the coverage limit is specified as an actuarial equivalent, it is not directly comparable to the limit in the President's proposal.

Under Breaux-Frist, all participating health care organizations—including HCFA—would be required to offer a high option plan that provided prescription drug and stop-loss coverage, in addition to coverage for Medicare core benefits. The President's proposal calls for a new voluntary prescription drug benefit, known as part D, and a new Medigap policy that would feature increased cost-sharing and stop-loss coverage. Under both proposals HCFA would contract with private entities to provide drug coverage for beneficiaries enrolled in its high option plan (Breaux-Frist) or in Medicare part D (President). Entities that managed the drug benefit for HCFA or private plans would be permitted to use cost containment mechanisms, such as formularies. The President's proposal includes incentives for private employers to retain drug coverage for their retirees.

Reform Outcomes Hinge on Design Details

The challenge of implementing Medicare reforms must be respected. As we have noted before, to determine the likely impact of a particular policy, details matter. Design choices and implementation policies can affect the success of proposed reforms. In addition, because difficult choices tend to meet with opposition from affected parties, the will to stay the course is equally important for successful reform. Following are just a few of the issues germane to Medicare reform that remind us of the proverb, "The devil is in the details."

To What Extent Should Premiums Be Adjusted for Geographic Variations in Health Care Markets?

For proposals that include elements of premium support, the task of determining the government's contribution toward each plan's premium raises several technical issues that have profound policy implications. In general, the government's share is greater or smaller, depending on whether the plan's premium is below or above the average of all plan premiums. However, some plans can incur higher-than-average expenses because of local market conditions outside of their control. Unless the government contribution is adjusted for these circumstances, beneficiaries could face higher out-of-pocket costs and plans could be at a competitive disadvantage. The Breaux-Frist proposal allows adjustments for medical price variation only. The President's proposal allows adjustments for medical price variation and regional differences in medical service use.

An adjustment for differences in local medical prices is clearly desirable under a premium support system. Without it, beneficiary premiums in high-price areas will tend to be above the national average. Adjusting the government contribution for input price differences can help ensure fair price competition between local and national plans and avoid having beneficiaries pay a higher premium, or higher share of a premium, simply because they live in a high-price area.

In addition, the use of medical services varies dramatically among communities because of differences in local medical practices. Under premium support approaches, plan premiums in high-use areas will likely exceed the national average. Whether, or to what extent, to adjust the government contribution for this outcome is a matter of policy choice. On the one hand, without an adjustment, beneficiaries living in high-use areas who join local private plans could face substantial out-of-pocket costs for circumstances outside of their control. Consequently, private plans in these areas might have difficulty competing with a traditional Medicare plan that charged a fixed national premium based on an overall average of medical service use. On the other hand, there have been longstanding concerns about unwarranted variations in medical practice. By not adjusting the government contribution for utilization differences, financial pressures could encourage providers to reduce inappropriate levels of use.

What Parameters Would Define Activities of Entity Administering Restructured Medicare Program?

Under either leading proposal, Medicare's administrative functions will include the oversight of plans' contracts. In today's Medicare+Choice program, this function is performed by HCFA. Under the President's plan, HCFA would retain this function; under Breaux-Frist, a quasi-independent board would administer Medicare.

Whatever the administrative entity is under Medicare reform, the following are questions that policymakers will want to consider. First, how will this entity's mission be defined? Will the emphasis be on controlling costs, protecting beneficiaries, maximizing choice, or some combination of these goals? Policy choices would flow from the stated mission. Second, how much independence would be permitted to the administrative entity to carry out its mission? Would it be appropriately shielded from the pressure exerted by special interest groups? Third, how would the administrative entity hold plans accountable for meeting Medicare standards? Would it rely chiefly on public accountability, in which the process and procedures for compliance are clearly defined and actively monitored, or on market accountability, by providing comparative information on competing plans and letting beneficiary enrollment choices weed out poor performers? Answers to these questions will determine, to a large extent, whether a restructured Medicare program will be administered effectively.

Addressing Immediate Concerns Can Aid Reform Efforts

Experiences in the Medicare+Choice program suggest lessons for implementing reforms effectively and provide a blueprint for actions that can be taken right away. In response to challenges faced in administering Medicare+Choice, HCFA has several initiatives underway that have faltered for various reasons—including resistance by special provider interests and insufficient agency capacity and expertise. However, the need to further these initiatives will grow in importance under comprehensive reform. Specifically, (1) improved risk adjustment is needed to ensure that Medicare's payments are fair both to the taxpayer and to individual plans, (2) better consumer information is needed to help beneficiaries make comparisons across plans, and (3) improved information systems and analysis capability are needed to promptly assess the impact of new payment and coverage policies.

Importance of Better Risk Adjustment

Adjusting for differences in beneficiary health status—commonly known as risk adjustment—enables plans to be fairly compensated when they enroll either healthier or sicker-than-average beneficiaries. Our work and that of others show that, partially because of an inadequate risk adjustment methodology, taxpayers have not benefited from the potential for capitated managed care plans to save money.[5] Under the competitive premium approach, the ability to moderate Medicare spending rests in part on how accurately analysts determine the government's share of a health plan's premium. Today's Medicare+Choice program is phasing in an

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

interim risk-adjustment methodology based on the limited health status data currently available. The challenge, for Medicare+Choice or any premium-based reform proposal, is to implement an improved method that more accurately adjusts payments, does not impose an undue administrative burden on plans, and cannot be manipulated by plans seeking to inappropriately increase revenues.

Need for Better Consumer Information

In an ideal market, informed consumers prod competitors to offer the best value. Our recent review of Medicare+Choice, however, showed that a lack of comparative consumer information dampened the program's potential to capitalize on market forces to achieve cost and quality improvements.[6] Despite HCFA's review and approval of health plans' marketing literature, many health plans distributed materials containing inaccurate or incomplete benefit information. Some plans did not furnish complete information on plan benefits and restrictions until after a beneficiary had enrolled. Others never provided full descriptions of benefits and restrictions. In addition, making comparisons across plans was difficult because, in the absence of common standards, plans chose their own format and terms to describe a plan's benefit package.

If Medicare is restructured to incorporate a competitive premium support approach, the need for beneficiaries to be well informed about their health care options becomes more critical. To guide its efforts to improve consumer information, HCFA should look to FEHBP—the choice-based health insurance program for federal employees. In FEHBP, for example, health plans are required to follow standard formats and use standard terms in their marketing literature. Informing Medicare beneficiaries, however, is likely to involve challenges not encountered in informing current and former federal employees. For one thing, the size of the Medicare program makes any education campaign a daunting task. Moreover, many beneficiaries have a poor understanding of the current program and may not understand how the proposed changes would affect their situations.

Need for Timely Information on Policy Effects

The ability to provide prompt and credible policy analyses of newly introduced changes is key during a period of significant transformation. Recent experience with the bold payment reforms established in the Balanced Budget Act of 1997 (BBA) illustrates this point. BBA was enacted in response to continuing rapid growth in Medicare spending that

[6]See *Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature* (GAO/HEHS-99-92, Apr. 12, 1999).

was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. In essence, BBA changed the financial incentives inherent in payment methods that, prior to BBA, did not reward providers for delivering care efficiently. Not surprisingly, affected provider groups conducted a swift, intense campaign to roll back the BBA changes. In the absence of solid, data-driven analyses, anecdotes were used to support contentions that Medicare payment changes were extreme and threatened providers' financial viability.

In testifying before the Congress in the fall of 1999, we remarked on the need for obtaining information that could identify and distinguish between desirable and undesirable consequences.[7] More recently, we recommended that HCFA establish a process to assess the potential effects of implementing legislated Medicare changes.[8] This process would entail developing baseline information from available claims data. The information from such assessments would be all the more critical during a period of implementing fundamental reforms.

Ensuring Program Sustainability Requires Early Warning Mechanism

Given the aging of our society and the increasing cost of modern medical technology, it is inevitable that the demands on the Medicare program will grow. The President's proposal reflects the belief that additional revenue will be necessary to meet those demands and ensure that health care coverage is provided to future generations of seniors and disabled Americans. Specifically, the President would earmark a portion of the projected non-Social Security surpluses for Medicare. According to the Administration, this action is designed to make Medicare financing a priority. This aspect of the proposal would entail a major change in program financing.

While Medicare will inevitably grow, it must not grow out of control. The risk is that federal resources may not be available for other national priorities, such as education for young people and national defense. In response, both Breaux-Frist and the President's proposals include elements designed to moderate future Medicare spending. Their approaches are untested, however, and it would be imprudent to adopt these—or any other reforms—without a means to monitor their effects. What is needed along with reform is a mechanism that will gauge spending and revenues and will sound an early warning if policy course corrections

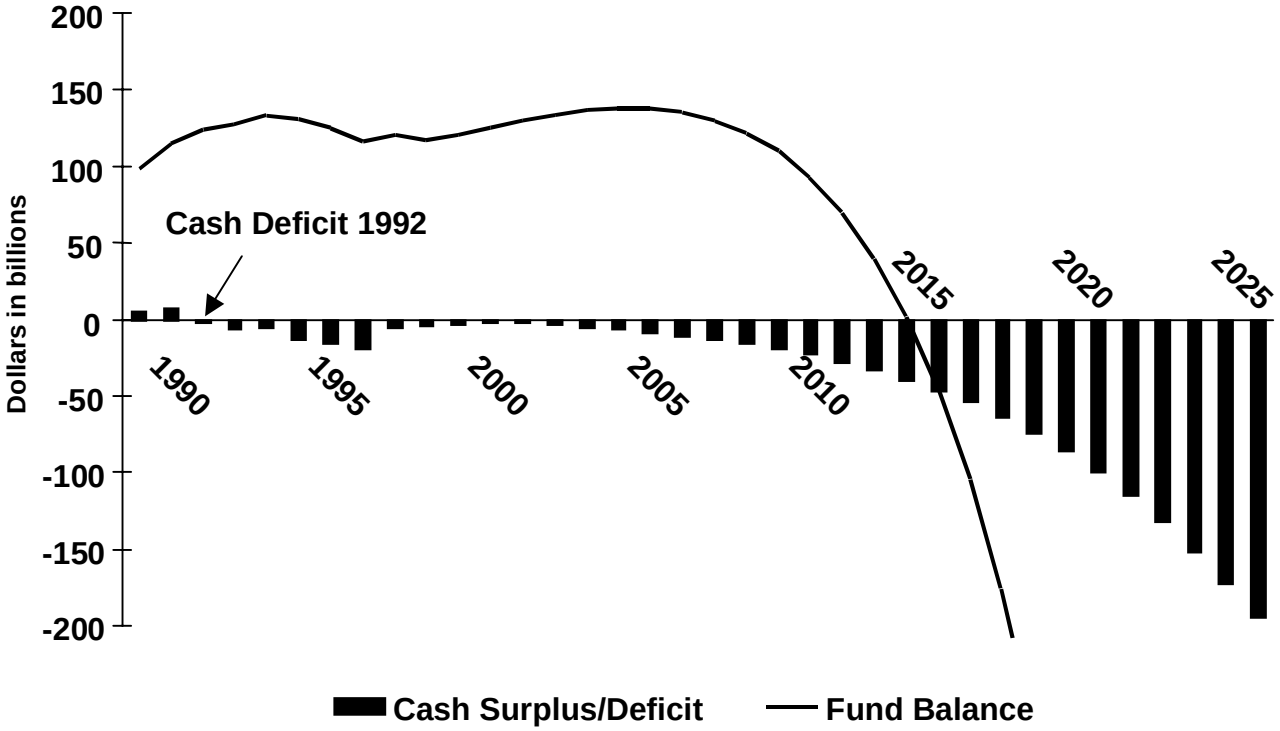
[7] *Medicare: Better Information Can Help Ensure That Refinements to BBA Reforms Lead to Appropriate Payments* (GAO/T-HEHS-00-14, Oct. 1, 1999) and *Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms* (GAO/T-HEHS-99-192, Sept. 15, 1999).

[8] *Medicare: Lessons Learned From HCFA's Implementation of Changes to Benefits* (GAO/HEHS-00-31, Jan. 25, 2000).

are warranted. Although both proposals include a warning mechanism, the Breaux-Frist approach would be a more comprehensive measure of program financing imbalances.

Under the current Medicare structure, the program consists of two parts. Medicare's HI Trust Fund, also known as part A, is financed primarily by payroll taxes paid by workers and employers. Supplementary Medical Insurance (SMI), also known as part B, is financed largely through general revenues. Currently, the financial health of Medicare is gauged by the solvency of the HI trust fund and not the imbalance between total revenues and total spending. The 1999 Trustees' annual report showed that Medicare's HI component has been, on a cash basis, in the red since 1992, and in fiscal year 1998, earmarked payroll taxes covered only 89 percent of HI spending. Although the Office of Management and Budget has recently reported a $12 billion cash surplus for the HI program in fiscal year 1999 due to lower than expected program outlays, the Trustees' report issued in March 1999 projected continued cash deficits for the HI trust fund. (See fig. 4.)

Figure 4: Financial Outlook of the Hospital Insurance Trust Fund, 1990 to 2025



Source: GAO analysis of data from the Office of the Actuary, Health Care Financing Administration.

When the program has a cash deficit, as it did from 1992 through 1998, Medicare is a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. To finance these cash deficits, Medicare drew on its special issue Treasury securities acquired during the years when the program generated a cash surplus. In essence, for Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs, or reduce the projected surplus.

When outlays outstrip revenues in the HI fund, it is tempting to shift some expenditures to SMI. Such cost-shifting extends the solvency of the HI

Trust Fund, but does nothing to address the fundamental financial health of the program. Worse, it masks the problem and may cause fiscal imbalances to go unnoticed. For example, in 1997 BBA reallocated a portion of home health spending from the HI Trust Fund to SMI. This reallocation extended HI Trust Fund solvency but at the same time increased the draw on general revenues in SMI while generating little net savings.

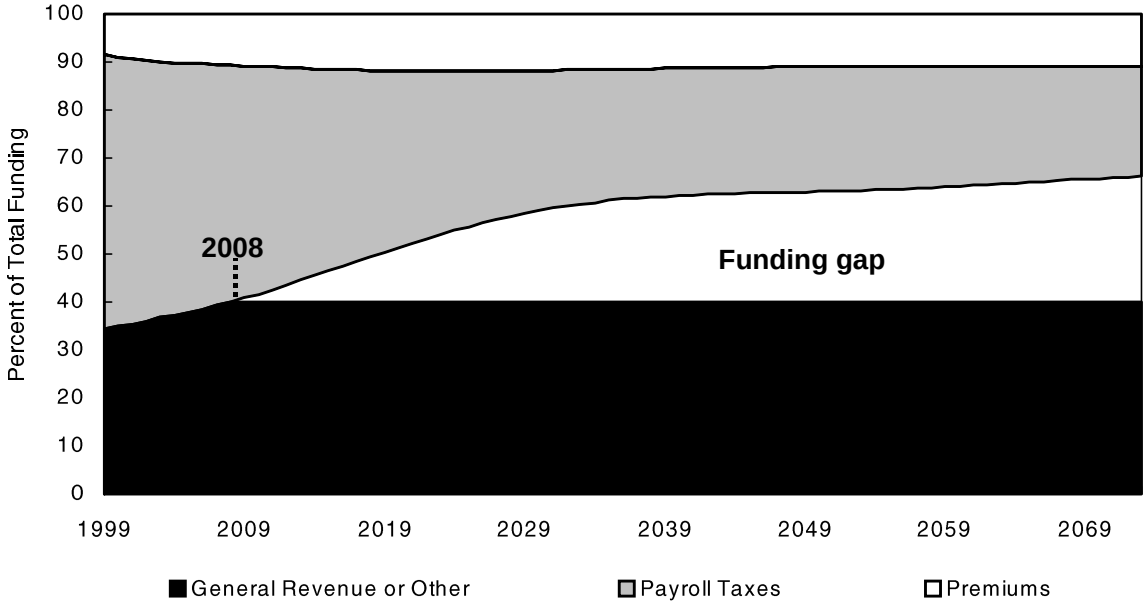
The President's plan preserves the program's divided financing structure and continues to rely on projections of HI Trust Fund solvency to warn of fiscal imbalances. By devoting a portion of the non-Social-Security surpluses to Medicare, the President's plan would extend the HI Trust Fund's solvency. This proposed infusion of general revenues represents a major departure in the financing of the HI program. Established as a payroll tax funded program, HI would now receive an explicit grant of funds from general revenues not supported by underlying payroll tax receipts. In effect, this grant would constitute a new claim on the general fund that would limit the ability to set budgetary priorities in the future. It would also further weaken the incomplete signaling mechanism of Medicare's future fiscal imbalances provided by the HI Trust Fund solvency measure.

Under an approach that would combine the two trust funds, a continued need would exist for measures of program sustainability that would signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues, the percentage of total federal revenues or gross domestic product devoted to Medicare, or program spending per enrollee. As such measures were developed, questions would need to be asked about the appropriate level of general revenue funding as well as the actions to be taken if projections showed that program expenditures would exceed the chosen level.

The Breaux-Frist proposal would unify the currently separate HI and SMI trust funds, and, in so doing, would eliminate the ability to shift costs between two funding sources. The Breaux-Frist early warning mechanism consists of defining program insolvency as a year in which general revenue contributions exceed 40 percent of total Medicare expenditures. At that time, the Congress would have several choices. It could raise the limit on general revenue contributions, raise payroll taxes, raise beneficiary premiums, reduce benefits, cut provider payments, or introduce efficiencies to moderate spending. Supporters of the Breaux-Frist proposal have suggested that a more comprehensive measure of program financing would be more useful to policymakers.

Current spending projections show that absent reform that addresses total program cost, this limit would be reached in less than 10 years. (See fig. 5.) These data underscore the need for reform to include appropriate measures of fiscal sustainability as well as a credible process to give policymakers timely warning when fiscal targets are in danger of being overshot.

Figure 5: Projected Funding Gap Under a 40-Percent Cap in General Revenue Contributions



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

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.

I am under no illusions about how difficult Medicare reform will be. The President's and Breaux-Frist proposals address 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 helping guarantee 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.

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

GAO Contacts and Acknowledgments

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