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MEDICARE

Options for Reform

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Medicare: Options for Reform

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you discuss efforts to reform the Medicare program. In March 1999 testimony before this Committee, the Comptroller General noted an emerging consensus that substantive programmatic reforms are necessary to put the Medicare program on a sustainable footing for the future. Budget projections show that health care is consuming ever larger shares of the federal dollar, thus threatening to crowd out funding for other valued social and economic activity. In addition, deliberations by the National Bipartisan Commission on the Future of Medicare as well as recent testimony before this Committee reflect public concern about the adequacy of Medicare's benefit package and the potential for erosion in the face of future budgetary pressures.

Over the past several months, this Committee has held a series of hearings on Medicare reform issues to determine the nature and extent of modernization needed and invited us to discuss the array of reform options. To that end, my remarks today will focus on a conceptual framework for considering the various possible combinations of reform options and lessons about implementing reforms learned from recent Medicare experience.

In brief, options to reform Medicare have two major dimensions: (1) expansion of Medicare's benefit package and (2) cost containment through financing and other structural transformations. Two commonly discussed benefit expansions are the inclusion of a prescription drug benefit and coverage for extraordinary out-of-pocket costs, known as stop-loss, or catastrophic, coverage. The financing reforms are reflected in three models: fee-for-service modernization, Medicare+Choice modernization, and a premium support system fashioned after the Federal Employees Health Benefits Program (FEHBP). Each of these models is designed, to different degrees, to alter program incentives currently in place to make beneficiaries more cost conscious and providers more efficient.

As the various reform options come under scrutiny, the importance of design details should not be overlooked. Our work on efforts to implement reforms mandated in the Balanced Budget Act of 1997 (BBA) is instructive regarding reform specifics. The principal lessons drawn from recent experience include the following:

- The particulars of payment mechanisms largely determine the extent to which a reform option can eliminate excess government spending while protecting beneficiary access to care.
- Revisions to newly implemented policies should be based on a thorough assessment of their effects so that at, one extreme, they are not unduly affected by external pressures and premature conclusions or, at the other extreme, they remain static when change is clearly warranted.
- For choice-based models to function as intended, consumer information that is sufficiently comparable to create competition based on cost and quality is essential.

Background

The future of an unreformed Medicare program includes a likely scenario in which an increasing population of seniors and technology advancements consume ever-growing shares of the nation's health care resources and federal budget. A growing consensus, which includes the trustees of the Medicare Hospital Insurance Trust Fund, notes that BBA took strong steps toward addressing this problem, but additional reforms are needed.

Medicare Spending Pressures Impel Need for Major Reform

Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom generation. For example, today's elderly make up about 13 percent of the total population; by 2030, this group will comprise 20 percent as the baby boom generation ages. Individuals aged 85 and older make up the fastest growing group of Medicare beneficiaries. Thus, in addition to the increased demand for health care services due to sheer numbers, the greater prevalence of chronic health conditions associated with aging will further boost utilization.

Compounding the cost pressures of serving a larger and needier Medicare population are the costs associated with the scientific breakthroughs for treating medical conditions and functional limitations. Technological and treatment advances have resulted in more services being provided to more beneficiaries. These services can restore health, reduce pain, increase functioning, and extend lives. At the same time, certain high-tech services may be of limited clinical value or fail to meaningfully improve the quality or length of life. Nevertheless, technological advances fuel the public's expectations that more health care is better.

The actual costs of health care consumption are not always fully transparent to consumers. Third-party payers generally insulate patients

and providers from cost-of-care decisions. In traditional Medicare, for example, beneficiaries are required to contribute 20 percent of the payment for physician visits and other services and a significant deductible for inpatient hospital care. These cost-sharing requirements are designed to give beneficiaries direct financial incentives to curb inappropriate care or services of marginal value. Yet the impact of the cost-sharing provisions is muted because about 87 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs.

While demographics and technology drive up health care utilization, pressure is mounting to update Medicare's outdated benefit design. At present, Medicare leaves beneficiaries without coverage for important services and at risk for large out-of-pocket costs due to coverage limitations. In 1965, when the program was first created, outpatient prescription drugs were not nearly as important a component of health care as they are now. Used appropriately, pharmaceuticals can cure diseases, improve quality of life, and sometimes substitute for more expensive services. Further, the Medicare benefit does not provide truly catastrophic coverage for those requiring lengthy hospitalizations. Nor are there any limits to the copayments required of beneficiaries needing extensive care from physicians and other providers. While Medicare coverage limits do not affect many beneficiaries, the limits can prove devastating for the few who exhaust the benefit without any supplemental coverage. Most private insurance options and Medicaid programs provide prescription drug and catastrophic coverage. Many individuals seek to similarly modernize Medicare's benefits. The cost implications, however, could be enormous. Their consideration needs to take account of the future unsustainability of the current program and its financing gap, which already greatly exceeds that of Social Security.

BBA Took Bold Steps Toward Modernizing Medicare

Enacted in 1997, BBA set in motion significant changes toward modernizing Medicare.

The act's combination of constraints on provider fees, increases in beneficiary payments, and structural reforms is expected to lower program spending by $386 billion over the next 10 years. Because certain key provisions have only recently or have not yet been phased in, the full effects on providers, beneficiaries, and taxpayers wrought by BBA will not be known for some time.

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

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

Dimensions of Reform Include Benefit Expansions and Financing Changes

Concerns continue to be voiced about the obvious gaps in protections for Medicare beneficiaries, which contrast with what is available for most individuals with private employer-based coverage. At the same time, competing concerns remain about the need to dramatically check Medicare's cost growth, even without adding new benefits. In response, a range of proposals has been made, each seeking to update Medicare's benefit package, restructure the program to constrain cost escalation, or both (see table 1).

Table 1: Major Dimensions of Medicare Reform, by Option

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

Benefit Expansion Reforms

Medicare's basic benefit package largely reflects the offerings of the commercial insurance market in 1965 when the program began. Although

commercial policies have evolved since then, Medicare's package—for the most part—has not.[1] For example, unlike many current commercial policies, Medicare does not cover routine physical examinations or outpatient prescription drugs or cap beneficiaries' annual out-of-pocket spending. Some beneficiaries can augment their coverage by participating in the Medicaid program (if they are eligible), obtaining a supplemental insurance policy privately or through an employer, or enrolling in a Medicare+Choice plan. However, these options are not available or affordable for all beneficiaries. Furthermore, to the extent that Medicaid and supplemental policies provide first-dollar coverage of services, the beneficiary population's sensitivity to service costs is dulled, contributing to some continued excess utilization. Consequently, many reform advocates believe that Medicare's basic benefit package should be brought into line with current commercial norms.

Two benefit reforms under discussion by policymakers are the inclusion of prescription drugs and stop-loss coverage that caps beneficiary out-of-pocket spending. Each involves a myriad of options, and assessing the merit of these reforms would depend on the specifics that may be included. 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; or coverage for selected drugs, such as those deemed to be cost beneficial. Such coverage decisions would hinge on understanding how a new pharmaceutical benefit would shift to Medicare portions of the out-of-pocket costs borne by beneficiaries as well as those costs paid by Medicaid, Medigap, or employer plans covering prescription drugs for retirees. How would these new program costs be shared between taxpayers and beneficiaries through premiums, deductibles, and copayments? Would subsidies be provided to help low-income, non-Medicaid eligible beneficiaries with these costs? The administration of the benefit raises other questions, such as, Who would set and enforce drug coverage standards among the private health plans participating in Medicare? and, for traditional Medicare, How would reimbursable prices be set? Price-setting options include using a formula based on market prices, negotiating directly with manufacturers, or contracting with a pharmaceutical benefit management company. A catastrophic, or stop-loss, coverage benefit would similarly entail its own set of design permutations, variables, and related consequences.

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

Financing and Other Structural Reforms

Many Medicare reforms are designed to slow spending growth to keep the program viable for the nation's growing aged population. Although the various proposals differ from one another in concept, they all include mechanisms to make beneficiaries more cost conscious and incorporate provider incentives to improve the efficiency of health care delivery. The various financing and structural reforms are organized around three general models: fee-for-service modernization, Medicare+Choice modernization, and a premium support system fashioned after FEHBP (see table 2).

Table 2: Medicare Reform: Options for Financing and Structural Change

	Fee-for-service modernization	Medicare+Choice modernization	FEHBP-type premium support
Pending	— Prospective payment systems (HHAs, hospital outpatient departments, and others)	— Health-based risk adjustment of rates — Annual enrollment and lock-in — Competitive pricing demonstration	
Potential	— Selective purchasing — Negotiated pricing — Case management for complex and chronic conditions — Utilization management — Medigap and beneficiary cost-sharing reforms	— Plan savings shared with program	— Premium based on offered or negotiated price — Beneficiary contribution based on plan cost — Traditional Medicare included but with enhanced flexibility and self-financed

Fee-for-Service Modernization

BBA improved the efficiency of Medicare's traditional fee-for-service program by substituting a variety of PPSs and other fee changes for the cost-based reimbursement methods and outdated fees that existed. Nevertheless, Medicare is still not an efficient purchaser. Adjusting its systems of administered prices and fees up or down to ensure beneficiary access or to capture potential savings as the market changes poses an overwhelming, if not impossible, challenge. Medicare largely remains a passive bill payer, exercising no meaningful control over the volume of services used. Proposals to modernize fee-for-service Medicare aim at providing flexibility to take advantage of market prices and introducing some management of service utilization.

Preferred provider arrangements, whereby insurers select certain providers because of their willingness to accept lower fees and their efficient style of practice, have become commonplace in the commercial

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

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

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

Medicare+Choice Modernization

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

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

The design of the Medicare+Choice program does not, however, allow taxpayers to benefit from the competition that currently occurs among health plans. If a plan can provide the Medicare package of benefits for less than the Medicare payment, it must cover additional benefits, reduce fees, or both.[2] Plans that offer enriched benefit packages—such as, including coverage for outpatient prescription drugs or routine physical examinations—may attract beneficiaries and gain market share. Medicare, however, pays the predetermined price even in fiercely competitive markets.

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

FEHBP-Type Premium Support

Although modernizing traditional Medicare and Medicare+Choice could improve control of program spending, several incentives would remain unaltered. For example, beneficiaries would remain partially insulated from the cost consequences of their choices. They would not benefit directly from selecting plans capable of delivering Medicare-covered benefits less expensively since the premiums they pay may well remain constant. Program payments to plans would continue to be established

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

administratively. The Bipartisan Commission and others have accordingly discussed the adoption of an FEHBP-type of premium support for Medicare. Such a reform would raise the sensitivity of both beneficiaries and providers to the costs of services.

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

Since most beneficiaries participate—and are expected to continue to participate—in traditional fee-for-service Medicare, its incorporation into the FEHBP-type system is seen as important. Under current arrangements, the only premium for participating in the traditional program is the fixed monthly amount that beneficiaries voluntarily pay to receive coverage for part B (physician, outpatient, and other services and supplies) or to be eligible to enroll in a Medicare+Choice plan. Because the premium amount represents a fraction of the program's cost and is deducted from beneficiaries' monthly Social Security payments, participants are less aware of the cost of the traditional Medicare program. The Bipartisan Commission discussed incorporating traditional Medicare as another plan under an FEHBP-type premium support system. Traditional Medicare would propose and negotiate premiums like any other plan and be expected to be self-financing and self-sustaining. Recognizing the challenge the latter requirement creates, the commission would also provide traditional Medicare more flexibility to manage costs using tools similar to proposals for fee-for-service modernization.

Incorporating traditional Medicare as another plan puts all plans on equal footing and maximizes beneficiary awareness of costs. However, the sheer size of the traditional program creates questions. How much flexibility can be granted to traditional Medicare given its market power? What will it

mean for a public plan to be self-sustaining and self-financing? Can it generate and retain reserves as a protection against future losses? How will losses be managed? Today's hearing is precipitated in part by the fact that the self-sustaining Hospital Insurance Trust Fund is projected to become insolvent. That prospect is intolerable. Similarly, insolvency of traditional Medicare, which may continue to enroll the majority of beneficiaries and may be the only plan serving many areas of the country, is not acceptable. The dilemma of how to guarantee traditional Medicare's solvency in the context of an FEHBP-type premium support system needs to be addressed.

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

Recent Medicare Reform Experience Illustrates the Need for Careful Attention to Reform Specifics

Our analyses of efforts to design and implement BBA reforms suggest several lessons as reform options come under closer scrutiny. Highlights from our recent studies on new payment methodologies, provider behavior in evolving markets, and Medicare+Choice information initiatives are instructive.

Engineering Payment Mechanisms to Achieve Desired Outcomes

The particulars of payment method reforms can affect whether reforms promote or deter unnecessary spending, ensure or impede access to appropriate health care, and facilitate or frustrate implementation efforts. Experience implementing BBA provisions mandating prospective payment systems and new payment rules for capitated managed care plans illustrates that design details matter.

Our review of the recently implemented PPS for SNF care is a case in point.[3] Under PPS, SNFs receive a payment for each day of care provided

[3]BBA phased in PPS for SNF care beginning on July 1, 1998.

to a Medicare beneficiary. Since not all patients require the same amount of care, this amount—called a per diem rate—is "case-mix" adjusted to take into account the nature of each patient's condition and expected care needs. In general, a PPS gives SNFs an incentive to provide daily services efficiently and judiciously because SNFs with costs higher than the adjusted per diem rate are at risk for the difference between their costs and the payments. The case-mix adjuster incorporated into the new PPS, however, allows a SNF to increase its payments by manipulating the services provided and thus bypass the need to become more efficient. Furthermore, whether a SNF patient is deemed eligible for Medicare coverage and how much will be paid are based on a facility's assessment of its patients. HCFA's ability to monitor these assessments, however, is limited. If SNFs manipulate service use to raise payments or make inappropriate patient assessments, expected savings from PPS could be threatened. Monitoring these assessments and determinations will be key to realizing the expected savings from PPS.

The Medicare+Choice payment rules established by BBA—in essence, reforming Medicare's previous HMO payment rules—similarly illustrates the need for effective design and adequate oversight. Currently, health plans that participate in Medicare+Choice receive a predetermined amount, known as a capitation payment, for each beneficiary they enroll. Because health plans are not paid for each service they provide, they have no incentive to oversupply services. In fact, the incentive is reversed; health plans may—at least in the short run—earn greater profits if they inappropriately withhold services or avoid enrolling beneficiaries who have above-average health care needs.

To reduce the undesired incentives of capitation, BBA mandated the implementation of a new Medicare risk adjustment methodology based on individuals' health status. The new risk adjuster is intended to reduce overall excess payments and improve the fairness of payments to individual health plans.[4] Although this new methodology has its own shortcomings, it represents an important improvement, particularly given health plans' limited ability to supply comprehensive health data on their members. HCFA anticipates that health plans soon will be able to supply more comprehensive data so that the agency can implement a more refined risk adjustment methodology in 2004.

[4]Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans (GAO/T-HEHS-99-72, Feb. 25, 1999).

Adequately adjusting payments—either prospective rates in fee-for-service Medicare or capitation amounts under managed care—becomes more important as Medicare improves its cost-containment efforts. Previously, there was little need to account for variations in patient needs when payment methods reimbursed the total cost of providing Medicare services or when rates were overly generous. Absent these wide margins for error and an increased emphasis on efficiency, case-mix adjustment and risk adjustment become increasingly important. When adjustment methods are inadequate, providers may be motivated to increase revenues by skimping on essential services, selecting healthier beneficiaries to serve, or both. Such behavior would thwart the twin goals of controlling spending while providing beneficiaries access to benefits.

Understanding Provider Behavior in Evolving Markets

Medicare experience also illustrates that an incomplete assessment of a new policy's effects can lead to potentially premature calls for action. Recently, the introduction of certain BBA reforms caused the affected provider communities to assert that immediate remedies were needed. Last fall, nearly 100 managed care plans decided to terminate their Medicare contracts or reduce the geographic areas they served—actions they attributed to payment changes mandated by BBA.[5] As a result, approximately 407,000 beneficiaries (7 percent of the managed care population) had to choose a new managed care plan or switch to fee-for-service.

Determining the extent to which BBA inappropriately precipitated the withdrawals is difficult, however. Managed care plans' participation decisions appear to be associated with a variety of factors. Indeed, our recent review suggested that a portion of the plan withdrawals occurred because plans decided they could not effectively compete in certain areas. Moreover, 40 managed care plans have recently applied (and some of these applications have already been approved) to serve Medicare beneficiaries. Medicare is not unique in experiencing changes in plan participation. In each of the past several years, FEHBP has seen new health plans participate while others have dropped out. This year, approximately 90,000 FEHBP beneficiaries had to switch plans because their original plan withdrew from the program.

As another example, between October 1, 1997, and January 1, 1999, over 1,400 HHAs closed. Providers have attributed these changes to BBA

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

payment and other reforms. After several years of large increases in home health expenditures, BBA mandated stricter limits on HHA payments, making it difficult for some agencies with expensive treatment patterns or those located in areas with many other HHAs to maintain current practices. Our recent analysis of HHA closures indicated that almost half of the closures occurred in just four states—three of which had previously experienced agency growth well above the national average. This pattern suggests that the closures could be a result of market corrections for recent overexpansion as much as a response to Medicare's efforts to control its spending on this benefit. Further, we found little evidence of beneficiary access problems due to closures, thus raising questions about industry calls for relaxing payment limits to help HHAs remain open.

It is clear, however, that payment and other reforms—even when correcting a poor policy of the past—have the potential to be disruptive for both beneficiaries and providers. Avoiding sudden, dramatic changes may be the key to minimizing disruptions and ensuring any reform's success. HCFA has wisely taken this approach, for example, in its decision to phase in the new managed care risk adjustment methodology over a period of several years. Nonetheless, it is not possible, or even desirable, to eliminate completely the natural disruptions that result from voluntary plan and provider participation decisions. The impact of these disruptions on beneficiaries needs to be ameliorated. Reforms that are accompanied by such safeguards are likely to receive greater public support.

Shaping Consumer Involvement in Choice-Based Models

Enabling beneficiaries to make better, more efficient health care choices underlies the majority of the reform options. Such improved decisionmaking hinges on beneficiaries having the necessary information to accurately assess their choices. BBA took significant steps to foster the success of the new choice-based managed care option by mandating improvements in Medicare's consumer information. The mandated initiatives were designed to help beneficiaries decide whether to choose traditional Medicare or an available Medicare+Choice plan. Prior to BBA's enactment, comparative information about health plan options was not systematically available to Medicare beneficiaries, as we reported in 1996.[6] Now, post-BBA, Medicare has a toll-free information telephone number, a web site, and plans to include some limited comparative information in its mass mailing of handbooks.

[6]Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

Despite these gains, substantial improvements are needed to enable Medicare seniors to become discriminating consumers. Recent analysis indicates that many beneficiaries poorly understand traditional Medicare and comprehend less about their managed care options. At present, Medicare beneficiaries must continue to rely largely on plan-supplied information, which currently lacks adequate standardization and reliability. In our recent study of plans' marketing and contract approval materials, we found information that was inaccurate, incomplete, or otherwise misleading, reflecting weak federal oversight of industry marketing efforts.[7] Information on the relative performance of health plans is also lacking, but the field of performance measurement is in its infancy, as experts struggle to reach consensus on which health outcome measures would be meaningful to consumers in general and Medicare beneficiaries in particular.

Considerations in Weighing Future Options

In his March 10 testimony to this Committee, the Comptroller General enunciated several criteria for assessing the merits of reform proposals that bear summarizing here: (1) affordability: reforms should address the current program's incentives inhibiting effective cost containment; (2) equity: reforms should not impose a disproportionate burden on particular groups of beneficiaries or providers; (3) adequacy: reforms should account for the need to foster cost-effective and clinically meaningful innovations, furthering Medicare's tradition of technology development; (4) feasibility: reforms must provide for such administrative essentials as implementation and monitoring; and (5) acceptance: to make program costs more transparent to the public, reforms must provide for sufficiently educating the beneficiary and provider communities to the realities of trade-offs required when significant policy changes occur. Most importantly, reforms need to address the sustainability of the program and ensure it does not consume an unreasonable share of our productive resources and does not encroach on other public programs or private sector activities. An incremental approach to changes of the magnitude likely required would enhance both their feasibility and acceptance.

The lessons learned in implementing BBA reforms touch on aspects of these five criteria. For example, payment mechanisms designed to achieve frugal program spending must avoid fostering perverse incentives for providers to skimp on services as a way to maximize revenue. In addition, interest group pressure to swiftly undo newly implemented reforms should

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

not overwhelm policy decisions, as misdiagnosed problems can lead to misguided solutions. Finally, consumer information can create stronger, quality-based competition when the information made available is sufficiently standardized and complete to make cost, benefit, and performance comparisons easy.

To apply these lessons in a fashion so that reforms meet the five criteria for success, implementation of reforms must be done with effectiveness, flexibility, and steadfastness. Effectiveness must include the collection of necessary data to assess impact—separating the transitory from the permanent and the trivial from the important. Flexibility is critical to make changes and refinements when conditions warrant and when actual outcomes differ substantially from the expected ones. Steadfastness is needed when particular interests pit the primacy of their needs against the more global interest of preserving Medicare.

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

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