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MEDICARE REFORM

Observations on the President's July 1999 Proposal

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Medicare Reform: Observations on the President's July 1999 Proposal

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the President's recent proposal to reform Medicare. According to the President, his proposal is intended to make Medicare more efficient, modernize the benefit package, and extend the program's long-term solvency.

When I last testified before you to discuss this topic in March,[1] there appeared to be an emerging consensus that substantive financing and programmatic reforms were necessary to put Medicare on a sustainable footing for the future. The long-term cost pressures facing this program remain today. Fundamental program reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Modernizing and upgrading Medicare's benefit package may be important, but such initiatives need to be considered in light of the broader financial challenges facing this program and the nation.

Against this backdrop, I want to acknowledge this Committee's efforts on Medicare reform over the past several months. The Committee has been diligent in exploring difficult issues pertaining to proposed options as well as the impact of reforms included under the Balanced Budget Act of 1997 (BBA). To date, this Committee and the Congress as a whole have remained steadfast in the face of intense pressure to roll back BBA's payment reforms and are waiting until strong evidence demonstrates the need for modifications. The President also deserves credit for looking out over a 15-year period in formulating budget proposals and proposing an historic reduction in publicly held debt that will help future generations better afford future commitments.

These initiatives are important because we must be especially prudent during this period of prosperity, even as recent estimates of budget surpluses have been increased. At the same time, we must remember that these are projected budget surpluses, and we know that the business cycle has not been repealed. Current projected surpluses could well prove to be fleeting, and thus we should exercise appropriate caution when creating new entitlements that establish permanent claims on future resources. While I don't relish being the accountability cop at the surplus celebration party, that's part of my job as Comptroller General of the United States.

[1]See Medicare and Budget Surpluses: GAO's Perspective on the President's Proposal and the Need for Reform (GAO/T-AIMD/HEHS-99-113, Mar. 10, 1999).

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 address the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and meaningful reform less feasible.

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

In this context, I'd like to make a few summary points before delving into the specifics of Medicare's financial health and the President's July 1999 proposal.

- The President's proposal contains programmatic reforms that reflect a good faith effort to advance the reform debate. It provides a baseline for further debate and consideration of reforming Medicare. As such, it is an important step in the goal of reaching a national consensus about how we are going to deal with the explosive cost of medical care for our elderly population in the decades to come. We understand that several Members of Congress, including Members of the Senate Finance Committee, plan to introduce their own reform proposals later in this session.
- The Congress and the President may ultimately decide to include some form of prescription drug coverage as part of Medicare. Given this expectation and the future projected growth of the program, some additional revenue sources may in fact be a necessary component of Medicare reform. However, it is essential that we not take our eye off the ball. The most critical issue facing Medicare is the need to ensure the program's long-range financial integrity and sustainability. The 1999 annual reports of the Medicare Trustees project that program costs will continue to grow faster than the rest of the economy. Care must be taken to ensure that any potential expansion of the program be balanced with

other programmatic reforms so that we do not worsen Medicare's existing financial imbalances.

- Given the size of Medicare's unfunded liability, it is realistic to expect that reforms to bring down future costs will have to proceed in an incremental fashion. The time to begin the difficult but necessary steps to reclaim our fiscal future is now when we have budget surpluses and a demographic "holiday" where retirees are a far smaller proportion of the population than they will be in the future.
- Ideally, the unfunded promises associated with today's program should be addressed before or concurrent with proposals to make new ones. To do otherwise might be politically attractive but not fiscally prudent. If additional benefits are added, policymakers need to consider targeting strategies and fully offsetting the related costs. They may also want to design a mechanism to monitor these and aggregate program costs over time as well as establish expenditure or funding thresholds that would trigger a call for fiscal action. Our history shows that while benefits are attractive, fiscal controls and constraints are difficult to maintain. In addition, any potential program expansion should be accompanied by meaningful reform of the current Medicare program to help ensure its sustainability, and the President's package of reforms provides a useful starting point.
- To qualify as meaningful reform, a proposal should make a significant down payment toward ensuring Medicare's long-range financial integrity and sustainability. As we testified before this Committee in March and again in June, proposals to reform Medicare should be assessed against the following criteria: affordability, equity, adequacy, feasibility, and acceptance. (See table 1.)

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

Affordability	A proposal should be evaluated in terms of impact on the long-term sustainability of program expenditures.
Equity	A proposal should be fair across groups of beneficiaries and to providers.
Adequacy	A proposal should include the resources to allow appropriate access as well as provisions to foster cost-effective and clinically meaningful innovations that address patient needs.
Feasibility	A proposal should incorporate elements to facilitate effective implementation and adequate monitoring.
Acceptance	A proposal should be transparent and should educate beneficiary and provider communities about its costs and the realities of trade-offs required when significant policy changes occur.

- People want unfettered access to desired health care, and some have needs that are not being met. However, health care costs compete with other legitimate claims in the federal budget, and their projected future growth threatens to crowd out future generations' flexibility to decide which of these competing priorities will be met. Thus, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between wants, needs, and what both individuals and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to domestic program issues. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations within a broader context of providing for other important national needs and economic growth.
- The President's latest proposal is projected to virtually eliminate the publicly held debt by 2015—this would be a significant accomplishment. Such an initiative would provide a substantial fiscal dividend by reducing interest costs, raising national savings, and contributing to future economic growth. This initiative would help us better afford our future commitments, but it would not alone be sufficient. Even if all future surpluses were saved, we would nonetheless be saddled with a budget over the longer term that at current tax rates could fund little else but entitlement programs for the elderly population. Reforms reducing the future growth of Medicare as well as Social Security and Medicaid are vital under any fiscal and economic scenario to restoring fiscal flexibility for future generations of taxpayers.

At this time, I would like to discuss the competing concerns at the crux of Medicare reform, in general, and issues to consider in assessing the President's proposal, in particular.

Competing Concerns Pose Challenges for Medicare Reform

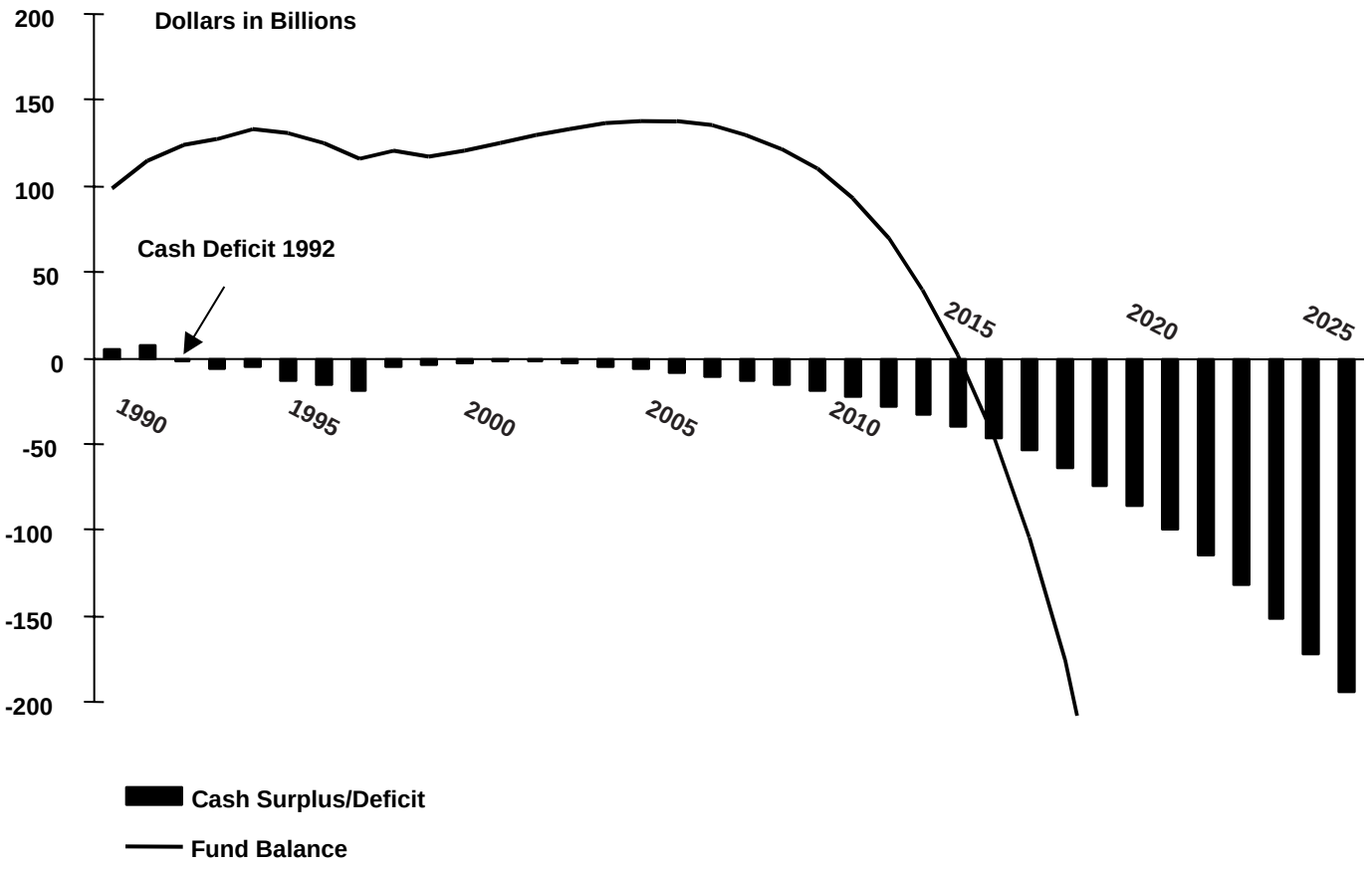
The current Medicare program, without improvements, is ill-suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years. On the other, the program is outmoded in that it has not been able to adopt modern, market-based management tools, and its benefit package contains gaps in desired coverage. Compounding the difficulties of responding to these competing concerns is the sheer size of the Medicare program—even modest program changes send ripples across the program's 39-million-strong beneficiary population and the approximately 1 million

health care providers that bill the program. Balancing the needs of these interests requires hard choices that this Committee, the Congress, and the National Bipartisan Commission on the Future of Medicare have had brought before them in their deliberations.

Medicare Is Already in the Red

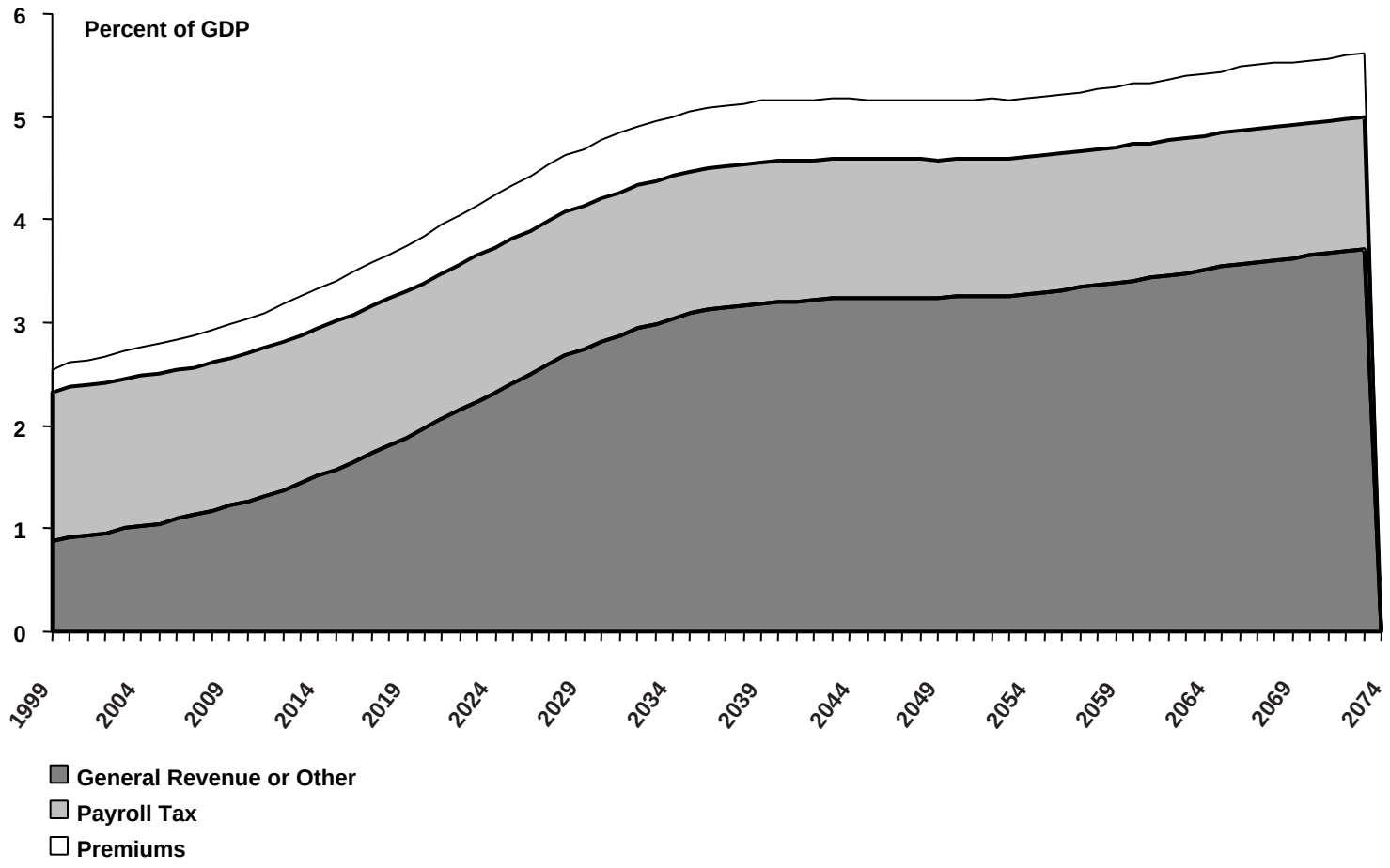
Unlike private trust funds that can set aside money for the future through investments in financial assets, the Medicare Hospital Insurance (HI) Trust Fund—which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services—is essentially an accounting device. It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

Figure 1: Financial Outlook of the Hospital Insurance Trust Fund



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

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

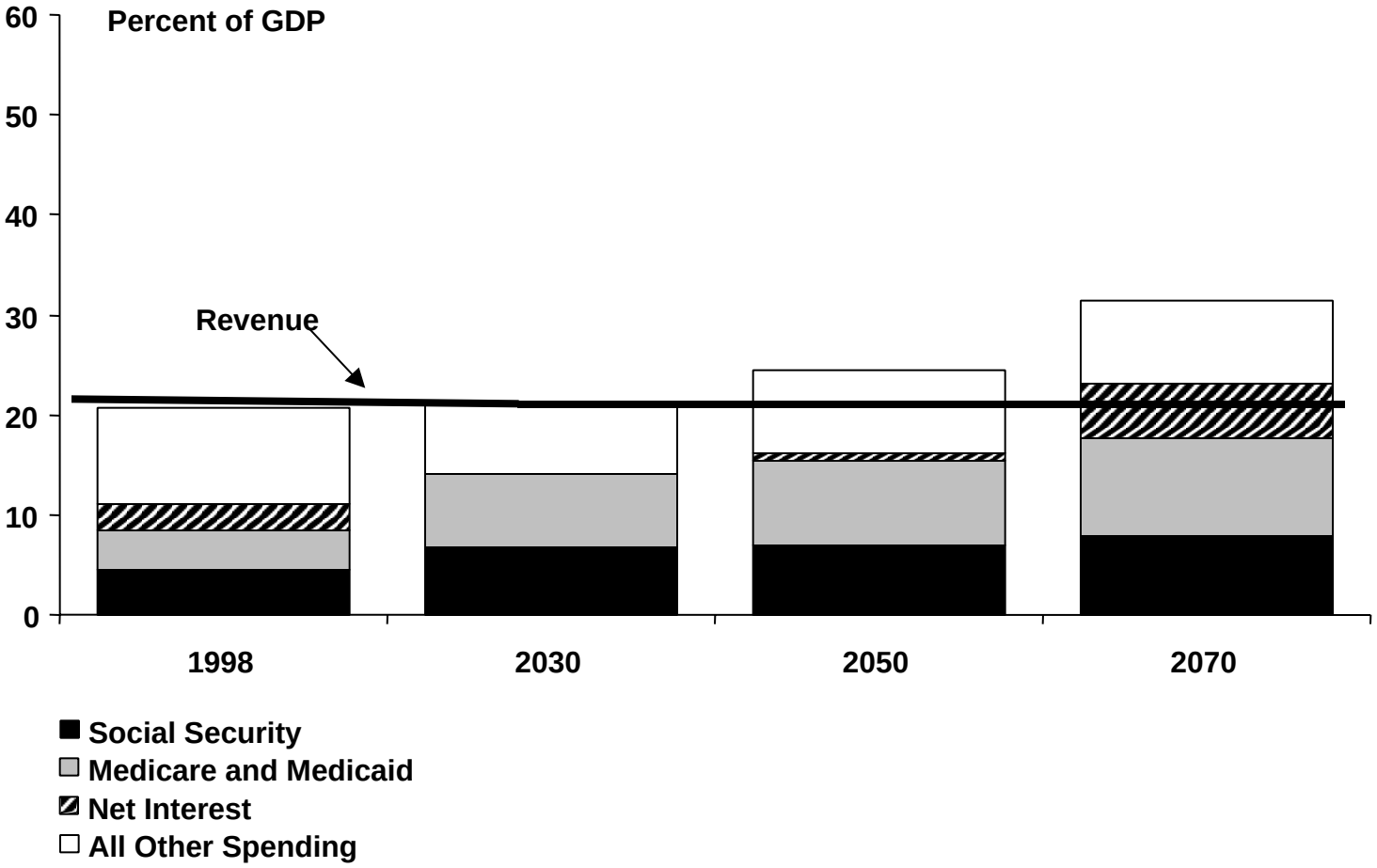


The progressive absorption of a greater share of the nation's resources for health care, like Social Security, is in part a reflection of the rising share of elderly in the population. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom. Today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages and the ratio of workers to retirees will have declined from nearly 4 to 1 today to roughly 2 to 1.

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

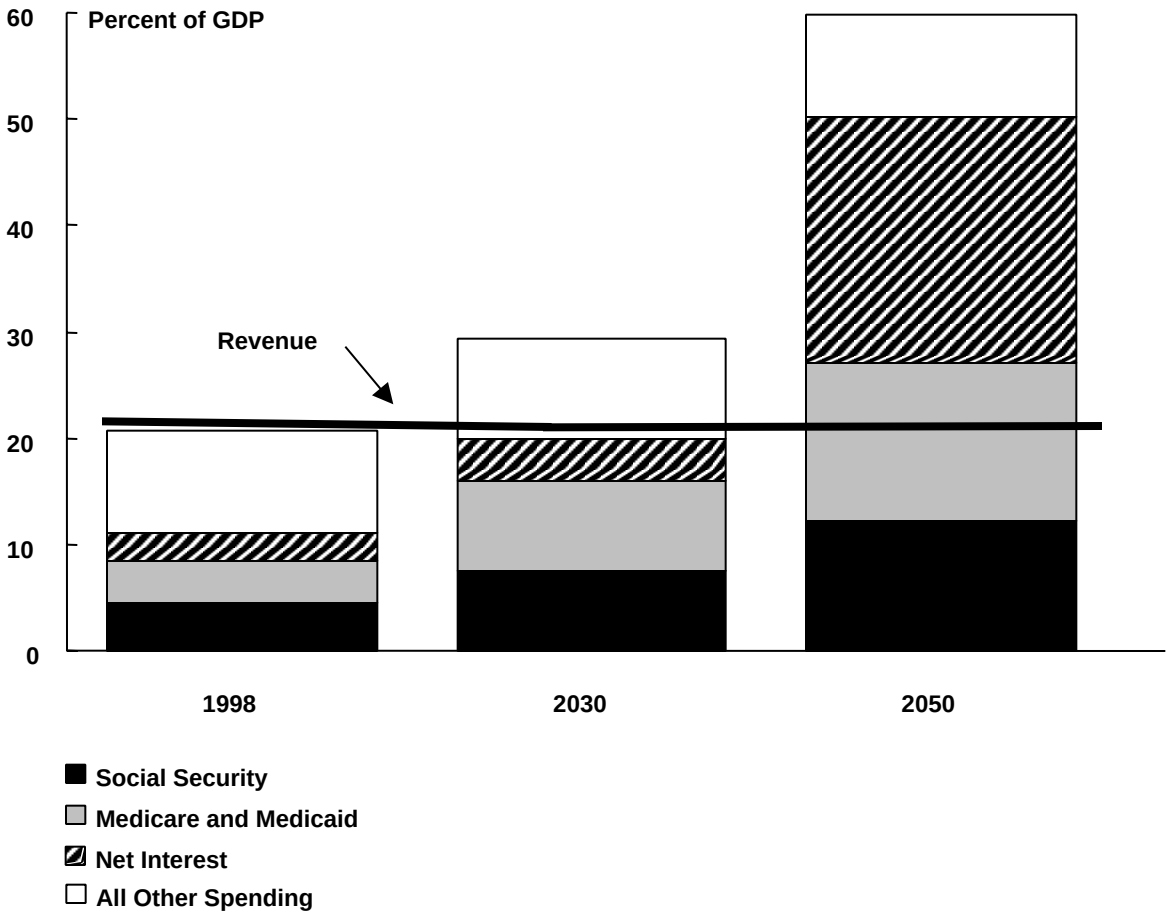
When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. GAO's updated budget simulations shows that to move into the future without changes in the Medicare, Social Security, and Medicaid programs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

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



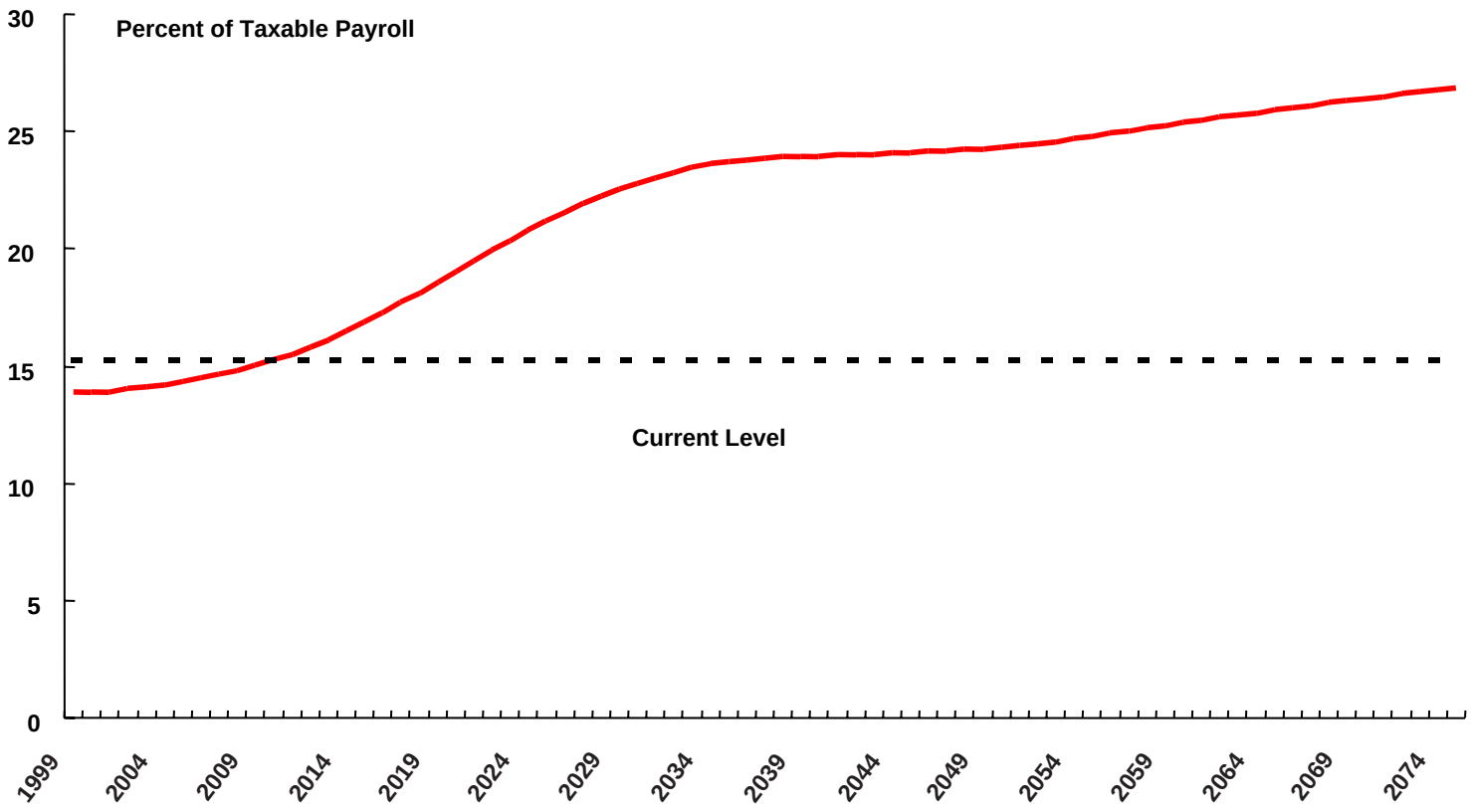
Note: In 2030, all other spending includes offsetting interest receipts.

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



When viewed together with Social Security, the financial burden of Medicare on the future taxpayers becomes unsustainable. As figure 5 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

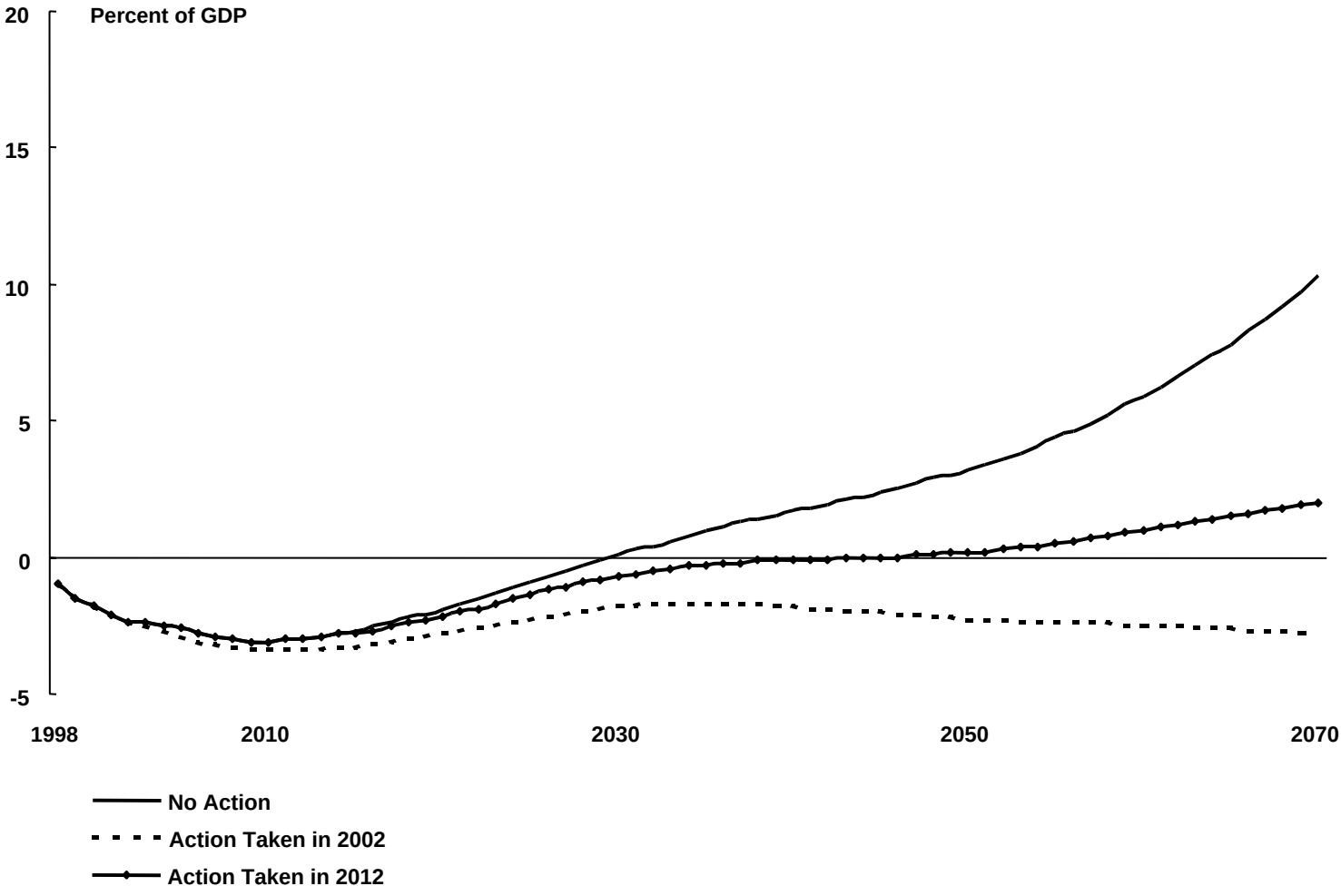
Figure 5: Social Security and Medicare Part A as a Percent of Taxable Payroll



Early action to address the structural imbalances in this program is critical. First, ample time is needed to phase in the kinds of changes needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. Our long-term budget simulations, as shown in figure 6, illustrates how critical early action on Medicare reform is to our long-term fiscal future. Any reforms slowing Medicare's per person growth rate from a projected average annual rate of 4.5 percent to 4 percent over a 70-year period would yield the kind of savings needed to truly establish a sustainable budget policy for the long term. Because of the high projected growth of Medicare in the coming

years, the earlier the reform begins, the greater the savings due to the effects of compounding. Reforms fully phased in by 2002 would enable us to maintain surpluses over the entire 70-year simulation period.

Figure 6: Federal Deficits as a Share of GDP Under Alternative Medicare Simulations



Medicare Out of Date Relative to Other Health Care Payers

In addition to its significant financial imbalance, Medicare is unsatisfactory from a programmatic perspective. BBA reforms were designed in part to modernize the program's pricing and payment strategies, but Medicare has not yet become a prudent purchaser. In its current form, the program lacks the flexibility to readily adjust its administered prices and fees in line with market rates and lacks the tools to exercise meaningful control over the volume of services used.

In addition, concerns continue to be voiced about the current coverage gaps in protections for Medicare beneficiaries, which contrast with what is available for younger Americans with private employer-based coverage. 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. For example, unlike many current commercial policies, Medicare does not cover routine physical examinations or outpatient prescription drugs or cap beneficiaries' out-of-pocket spending. Two-thirds of Medicare beneficiaries obtain prescription drug 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, in some cases, these options do not provide adequate coverage, leaving high users with significant out-of-pocket costs; for many of the remaining third of beneficiaries, these options are inaccessible altogether, either because they are not available—in the case of a Medicare+Choice plan—or are not affordable. In short, many reform advocates believe that Medicare's basic benefit package should be brought into line with current commercial norms.

The challenge facing the Congress today is to identify reform options that satisfy the need to make Medicare's costs more sustainable while addressing certain gaps in coverage. With respect to prescription drug coverage, striking this balance is particularly difficult. On the one hand, financing a prescription drug benefit would be a costly proposition. From 1992 to 1997, prescription drug spending grew on average by 11 percent a year, compared with a 5-percent average growth rate for health expenditures overall. As a result, drug spending during that same period consumed a larger share of total health care spending—rising from 5.6 percent to 7.2 percent. In addition, the elderly population, which constitutes the majority of Medicare beneficiaries, consists of relatively high users of prescription drugs. In 1995 (the most recent year for which data are available), annual drug costs were $600 per elderly person,

compared to just over $140 for a nonelderly individual. On the other hand, the lack of a prescription drug benefit creates a significant burden for those who have little or no supplemental coverage. In 1999, an estimated 20 percent of Medicare beneficiaries—some of whom lack any supplemental coverage—will have total drug costs of $1,500 or more.

Number and Size of Affected Parties Make Medicare Reform Exceptionally Difficult

The fact that changes to Medicare can create seismic reverberations is not surprising. Health care spending accounts for one-seventh of the nation's economy, and Medicare is the nation's single largest health care payer. The program's beneficiary populations consist of roughly 35 million seniors and 4 million disabled individuals under age 65. HCFA estimates that the program's billers—physicians, hospitals, equipment suppliers, and other providers of medical services—number about 1 million.

BBA payment reforms are the latest case example illustrating the intensity of reactions from providers affected by legislative changes. BBA sought to lower future payments to Medicare's managed care plans and to providers historically paid through cost reimbursement. Affected providers are currently seeking to repeal various BBA provisions, with some relying on anecdotal evidence rather than systematic analysis to make their case. A recent illustration is the reporting of health plan withdrawals from the Medicare+Choice program. Plans cite, and the press reports, inadequate payment rates as the reason for dropping out of Medicare or reducing enrollees' benefits. GAO has another point of view based on our fact-gathering and analyses.

BBA sought to moderate Medicare's payments to managed care plans because, ironically, Medicare managed care cost, not saved, the government money. That is, the government was paying more to cover beneficiaries in managed care than it would have if these individuals had remained in the traditional fee-for-service program. In our recent published work, we noted that BBA has reduced, but not eliminated, excess payments.[2] In fact, Medicare's payments to some plans are generous enough to finance prescription drugs and other extras not available to the majority of senior and disabled beneficiaries that remain in traditional Medicare. We have also reported that factors additional to or even exclusive of payment rates—including competition and other market

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

conditions—played a significant role in plan dropouts.[3] The question this raises for policymakers is to what extent should they be concerned about health plan dropouts from Medicare when plan participation means that the government finances non-Medicare benefits for a minority of beneficiaries while paying more for these beneficiaries than for those in traditional Medicare. Among other lessons, however, the intensity of pressure to roll back BBA's curbs on managed care rate increases teaches us the difficulty that this Committee and the Congress as a whole face in making appropriate Medicare payment reforms.

President's Medicare Reform Proposal

The President's proposal to reform Medicare is intended to function on two levels: first, as a Medicare financing strategy and, second, as a package of programmatic reforms. On the basis of GAO's work on these topics, I would like to discuss several key issues.

Financing Aspect of President's Proposal

The President proposes to use 13 percent of the projected budget surpluses over the next 15 years to provide additional Treasury securities to the HI Trust Fund and partially offset the cost of the proposed prescription drug benefit.[4] This aspect of the proposal has important implications for the budget as a whole as well as for Medicare financing in particular.

With regard to its more general budgetary significance, the President's proposal is part of a broader initiative that would save a major share of the surplus to reduce debt held by the public. Most of the surplus transferred to Medicare would be invested in federal Treasuries and the President is proposing budget enforcement mechanisms—"lockboxes"—that would ensure that these transfers be used solely to reduce publicly held debt. As the President himself has suggested, debt reduction plays a critical role in enhancing our economic capacity to finance our burgeoning commitments over the long run. The President's June Midsession Review projects that his proposals would reduce debt held by the public by $3.6 trillion over the next 15 years, virtually eliminating publicly held debt by 2015. Approximately two-thirds of total projected unified budget surpluses

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

[4]In the Midsession Review, the President proposes to transfer $794 billion of the projected 15-year surpluses to Medicare—$723 would be used to acquire additional Treasury securities for the HI Trust Fund and the remainder would help pay for the proposed drug benefit. Excluding financing costs associated with the President's proposed new spending, this amount represents 15 percent of projected surpluses. However, when computed to include these costs, the transfer represents 13 percent of total projected surpluses.

would be used to reduce the debt through lockbox provisions dedicating all of Social Security's surpluses, and about a quarter of the on-budget surplus would be transferred to Medicare for debt reduction. However, because of the transfers to Medicare, debt held by government accounts would increase by about $1 trillion over the 15-year period.

The reduction in publicly held debt proposed by the President —although less than the baseline, which assumes that all surpluses would be saved—would confer significant short- and long-term benefits to the budget and the economy. Our own work on long-term budget outlooks illustrates the benefits of maintaining surpluses for debt reduction. Interest on the debt represents today the third largest expenditure in the federal budget. Reducing the publicly held debt reduces these costs, freeing up budgetary resources for other programmatic priorities. Under the President's plan, interest expense would fall from $229 billion in 1999 to about $10 billion in 2014. For the economy, lowering debt increases national saving and frees up resources for private investment. This in turn leads to stronger economic growth and higher incomes over the long term.

Over the last several years, our simulations illustrate the long-term economic consequences flowing from different fiscal policy paths.[5] Our models consistently show that saving all or a major share of projected budget surpluses ultimately leads to demonstrable gains in GDP per capita over a 50-year period. GDP per capita would more than double from present levels by saving most or all of projected surpluses, while incomes would eventually fall if we failed to sustain any of the surplus. Although rising productivity and living standards are always important, they are especially critical for the 21st Century, for they will increase the economic capacity of the projected smaller workforce to finance future government programs along with the obligations and commitments for the baby boomers' retirement.

With regard to the Medicare program itself, the proposed "transfer" of surpluses would extend the solvency of the HI Trust Fund on paper from 2015 to 2027. This initiative, however, represents a major departure in financing for 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. Treasury securities held by the Trust Fund have always represented the value of the loan provided by the HI program's prior payroll tax surpluses to the Treasury. Under the

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

President's proposal, the value of securities held by the HI Trust Fund would exceed that supported by earlier payroll tax surpluses and this grant would constitute a new claim on the general fund for the future. In effect, the proposed transfer would make the HI Trust Fund financing look more like that of the part B SMI Trust Fund, which obtains 75 percent of its funding from the general fund.

As the foregoing suggests, this is a major change in the theoretical design of the HI program that deserves full and open debate. The size of the imbalances between Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional financing from general revenues. The President argues that Medicare should be guaranteed a share of the benefits resulting from the fiscal improvement that debt reduction and lower interest costs would bring about. However, using surpluses to finance Medicare entails significant risks.

The President's proposal to grant Medicare additional Treasury securities creates the risk of reducing transparency about the underlying financial condition of the HI Trust Fund. Although arguably justified as a way to lock in debt reduction, the transfers are not necessary to do this. What concerns me is the transfers extend the solvency of the HI Trust Fund on paper without making the hard choices needed to make the whole Medicare program more sustainable in economic or budgetary terms. Increasing the HI Trust Fund balance alone, without underlying program reform, does nothing to make the Medicare program more sustainable—that is, it does not reduce the program's projected share of GDP or the federal budget. From a macro perspective, the critical question is not how much a trust fund has in assets, but whether the government as a whole has the economic capacity to finance all of Medicare's promised benefits—both now and in the future.

In fact, the transfer would interfere with the vital signaling function that trust fund mechanisms can serve for policymakers about underlying fiscal imbalances in covered programs. The greatest risk is that the proposed transfer will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program through 2027—well into the peak of the baby boomers' retirement. Furthermore, increasing the Trust Fund's paper solvency does not address cost growth in the SMI portion of Medicare, which is projected to grow even faster than HI in coming decades.

The President's proposal to transfer funds to the HI Trust Fund would, in effect, increase the general fund contribution to total Medicare funding. Increasing the balances of Treasury securities owned by the HI Trust Fund alone would increase the formal claim that the Trust Fund has on future general revenues since the Trust Fund's securities constitute a legal claim against the Treasury. These are resources that will not be available for competing priorities in either domestic or defense areas. When considering both HI and SMI programs together, the share of general fund financing would grow under the President's proposal from its current level of 34 percent to about 57 percent by 2027. Although the programs' costs are projected to grow to these levels in the absence of any changes, the proposals would lock in general fund financing of these costs through the transfer of additional Treasury securities. In effect, the proposal would likely ensure that projected Trust Fund shortfalls through 2027 will be financed through the general fund rather than through Medicare program reforms.

Finally, any proposal to allocate surpluses is vulnerable to the risk that those projected surpluses may not materialize. Commitments often prove to be permanent while surpluses can be fleeting. Although recent budget forecasts have proven to be too pessimistic, the history of budget forecasts should remind us not to be complacent about the certainty of these large projected surpluses. In its January 1999 report, the Congressional Budget Office (CBO) compared the actual deficits or surpluses for 1988 through 1998 with the first projection it produced 5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO says its errors averaged about 13 percent of actual outlays. Such a shift in 2004 would mean a swing of $250 billion and about $300 billion in 2009. Accordingly, any permanent commitments that are dependent on the realization of a long-term forecast should be considered carefully.

Programmatic Aspects of President's Proposal

The President's reform plan also consists of several programmatic changes—most notably, a proposal for health plans to compete on the basis of price and the addition of a prescription drug benefit. The plan also calls for measures intended to help Medicare operate more efficiently or strengthen future financing, including the following: create a preferred provider option in which beneficiaries would be rewarded with lower cost-sharing requirements when choosing providers preferred by Medicare; expand the use of centers of excellence, in which providers that specialize in performing such procedures as coronary artery bypass surgery receive a global fee for all services provided rather than a separate

fee for each service; extend certain BBA provisions that reduce provider payment rate increases, thus helping to slow future program spending; impose a 20-percent copayment for clinical laboratory services; and index the part B deductible for inflation.

Overall, the Office of Management and Budget estimates that the changes in price competition and cost incentives would achieve savings of $72 billion over 10 years. However, these savings would offset only 60 percent of the total projected $118 billion for the new prescription drug benefit, with the remainder being financed through a portion of the general fund transfers, as discussed earlier. CBO's re-estimate of the President's proposal—projecting a higher cost for the drug benefit and smaller savings—underscores the uncertainty and volatility inherent in health care cost estimates. This argues for proceeding cautiously in expanding the Medicare program to include new benefits.

Now I would like to elaborate on the competitive pricing of health plan premiums and the addition of a prescription drug benefit.

Provisions for Proposed Health Plan Competition

Under the President's proposal, private health plans serving Medicare beneficiaries would compete on the basis of cost and quality to provide Medicare-covered benefits. Instead of administratively established payment rates, plans would set their own premiums for a standard package of benefits. The government's contribution would be limited to 96 percent of the estimated fee-for-service costs of enrolled beneficiaries. Beneficiaries choosing plans priced under the 96-percent level would pay reduced part B premiums and could retain these savings or use them to buy optional benefits. Beneficiaries choosing plans exceeding the 96-percent level would pay an amount additional to the standard part B premium.

In principle, the competitive pricing of managed care plan premiums has considerable merit and could help produce savings for both the program and beneficiaries. Using market forces to set prices would constitute a major advance. Price competition among plans is more likely to lead to payments that appropriately compensate efficient plans rather than the excessive payment levels that have resulted from administratively set prices. Taxpayers would benefit in two ways: first, because the government's contribution would be lower than if beneficiaries remained in traditional Medicare and, second, because the government would net 25 percent of the savings achieved through the enrollment of beneficiaries in plans priced below the government contribution cap.

However, the extent to which price competition among health plans would produce savings depends on the design and implementation particulars—which the Administration has not yet made available. Our previous work demonstrates conclusively that health plan payments must take into account the health status of enrolled beneficiaries—that is, be risk adjusted—if savings are to be realized.[6] Also critical is how Medicare will estimate average fee-for-service spending and calculate its contribution to health plan premiums. Currently, average fee-for-service spending varies dramatically across geographic areas, due primarily to differences in beneficiaries' use of medical services and, to a lesser extent, differences in local prices. Some of the variation can reflect an area's inappropriate use of services—either too low or too high. Because such inappropriate utilization is embedded in the fee-for-service expenditure data, benchmarking plan payments against current fee-for-service spending levels requires careful scrutiny. The Administration indicates it will incorporate a geographic adjustment that will take into consideration these local differences, but it has released few details on how this process would work.

Provisions for Proposed Prescription Drug Benefit

The second major programmatic element of the President's proposal is the addition of a prescription drug benefit. Essentially, the prescription drug benefit would be voluntary, requiring a premium separate from the current part B premium and 50-percent copayment from beneficiaries for each prescription. Beneficiaries would be permitted to enroll for the benefit, generally, only when they are first eligible. The benefit is designed to be phased in. In 2002, the beneficiary's premium would be about $24 per month, with Medicare paying up to $1,000 per-beneficiary annually. By 2008, the premium would rise to about $44 per month, with Medicare paying up to $2,500 per-beneficiary annually. The poorest beneficiaries would not pay premiums or copayments, and other low-income beneficiaries would receive premium assistance.

Enrollees in Medicare managed care plans would receive their prescription drug benefit as they do currently. Beneficiaries in traditional Medicare would get their benefit through private companies called "pharmacy benefit managers" (PBM) or through entities that essentially operate like a PBM. In the private sector today, PBMs under contract with third-party payers administer and manage enrollees' prescription drug benefit. As proposed for Medicare, PBMs would be paid a fee for managing

[6]See 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) and Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

the drug benefit and would competitively bid to manage the benefit for a particular geographic area. They would negotiate prices with drug manufacturers.

Several of the prescription drug benefit provisions contain elements of fiscal discipline, transparency, and economy. For example, the separate premium—for which the government's share must be calculated each year—serves as a mechanism to track the benefit's aggregate costs. The 50-percent copayment and the annual cap are likely to help control excessive utilization. The one-time enrollment opportunity encouraging beneficiary participation would help spread risk across a larger pool of individuals, not just among the high users. This provision would help prevent a situation in which a greater contribution from the government would be needed to finance the benefit if only frequent users chose to enroll. Finally, premium and copayment subsidies would help relieve low-income beneficiaries from some of the burden of high out-of-pocket costs.

We note, however, the following design and implementation concerns regarding the drug benefit as proposed.

- Cost of the benefit. This new benefit is not fully paid for by other offsetting program changes. General funds from the projected surpluses make up the difference; but as I said earlier, this would finance a permanent benefit expansion with an uncertain revenue stream.
- Targeting of the benefit. A primary means of allocating limited resources is to target them on the greatest needs. With the exception of greater federal subsidies for certain near-poor Medicare beneficiaries, the proposed coverage is not targeted to need. The proposal provides first-dollar coverage rather than using a deductible that would make beneficiaries more cost-sensitive and would reduce total program expenditures. In addition, it would cap the benefit at $2,500, leaving some beneficiaries incurring catastrophic drug expenses without coverage.
- Substitution for employer-provided. The proposed benefit could mean that some costs borne by employers and retirees through retiree health benefit plans would become the responsibility of the federal taxpayer. A partial subsidy to employers—equaling two-thirds of what the program would pay for Medicare drug coverage—aims at minimizing the number of employers and retirees dropping employer-sponsored coverage. How effective the subsidy works in preventing substitution remains to be seen. Some employers may still find it advantageous to drop coverage. Retirees may actually approve if they prefer to obtain the full drug benefit from

Medicare and receive alternative benefits from their former employers, including "wrap-around" drug coverage that fills some of the gaps in the Medicare benefit.

- Uneven impact across states. In assisting low-income Medicare beneficiaries with premiums and cost-sharing of the new drug benefit, the President's proposal would build on existing Medicare "buy-in" programs, in which the federal government and the state together subsidize—through Medicaid—some combination of Medicare premiums, deductibles, and copayments. For individuals between 100 and 150 percent of the federal poverty level, the President's proposal provides for full federal funding of the prescription drug benefit; for those below 100 percent, the proposal calls for shared funding between the federal government and the state.[7] States would experience varying levels of fiscal relief or additional burden, depending on the extent to which they ensured that these individuals receive their benefit.

  More than 40 percent of low-income individuals eligible for the current Medicare buy-in benefits are not enrolled, and enrollment is particularly low among eligible individuals above the federal poverty level. The inclusion of the drug benefit would create a greater incentive for these beneficiaries to enroll in the Medicare buy-in program. Further, the full federal funding of the drug benefit for those above the federal poverty level could help reduce the disincentives that states face when considering whether to actively encourage beneficiaries to enroll in a federally mandated program that is not fully funded by the federal government. At the same time, significantly greater enrollment in the Medicare buy-in programs resulting from the new drug benefit and outreach efforts would increase a state's financial exposure for matching funds that subsidize beneficiaries' Medicare part B premiums. States with eligibility standards for full Medicaid benefits that are well below the federal poverty level would be more likely to incur additional obligations.

- Obstacles to realizing the savings potential of PBMs. In the private sector, the negotiations between PBMs and drug manufacturers and PBMs and pharmacies are determined privately, whereas Medicare—as a public program—is required to have transparent policies that are determined openly. If a PBM, as a Medicare contractor, has to conduct such negotiations in public, achieving meaningful discounts for Medicare may be difficult. Moreover, a PBM's span of control, not specified in the President's proposal, could have mixed effects on the PBM's ability to

[7]Beneficiaries with income between 135 and 150 percent of the federal poverty level would pay a partial, sliding-scale premium based on their income.

control drug costs. On the one hand, the greater the number of beneficiaries within that span, the greater the potential for moving market share to take advantage of manufacturers' discounts; on the other hand, the greater the number of affected providers, the greater the pressure for the PBM to include all willing providers, which would undermine its ability to negotiate with selected manufacturers or providers offering the best terms.

Finally, I would caution that the creation of a new and compelling benefit for this program not exacerbate Medicare's financial problems and should include a way to monitor future costs to the government. Although the President's proposed 50-percent copayment could serve to control excessive utilization, that copayment rate and other financial control mechanisms are subject to erosion. As you know, the part B premium originally was set at a level to finance 50 percent of the part B program costs. However, less than 10 years later, the method for setting the part B premium was tied to changes in cost of living, resulting in premiums dropping below 25 percent of the program costs. Under current law, the premium is set at 25 percent of premium costs, far from the original cost-sharing arrangement, and the projected costs of the part B program are expected to continue to escalate, with general Treasury revenues paying 75 percent of those costs.

Given this history, it would be prudent to target the benefit to those most in need and include additional safety valves to check excessive program cost growth. If expenditure or funding thresholds were established, they could be used to trigger periodic congressional reviews and could prompt legislative action if spending projections showed that the thresholds were likely to be exceeded.

Concluding Observations

I would like to conclude by pointing to the historic opportunity presented by the recently projected surpluses. Some advocate spending the surpluses to address a host of pent-up demands on the spending and/or revenue sides of the budget, built up from years of struggling with and finally succeeding in eliminating deficits. Updating Medicare's benefit package is but one of a number of legitimate claims being made for the use of these surpluses.

It is my hope that in considering all of these competing claims in the present we also 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 serve to preserve some capacity to make their own choices by both strengthening 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.

In this regard, I think the President's proposal has the advantage of putting forth a long-term plan that would help promote future growth by paying down the publicly held debt. Many in the Congress putting forth constructive reform proposals for Social Security and Medicare also deserve credit—a sustainable future involves both fiscal policies that would improve national savings as well as real programmatic reforms to reduce the burdens of obligations and commitments on future generations.

In determining how to finance the Medicare program, much is at stake—not only the future of Medicare itself but also preserving the nation's future fiscal flexibility to pursue other important national goals and programs. Mr. Chairman, I feel that the greatest risk lies in extending the HI Trust Fund's solvency while 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.

General fund infusions and expanded benefits may well be a necessary part of any major reform initiative. Updating the benefit package is probably a key part of any realistic reform program to address the legitimate expectations of an aging society for health care both now and in the future. The President's proposal also includes a broader package of reforms that provide a good point of departure for addressing Medicare's current fiscal imbalance. However, more needs to be done to ensure the program's longer term sustainability. In addition, the Congress should consider adequate fiscal incentives to control costs and an enhanced targeting strategy in connection with any proposal to provide a prescription drug benefit.

I am under no illusions about how difficult Medicare reform will be. Experience shows that forecasts can be far off the mark. Benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. Recent experience implementing BBA reforms provides us some sobering lessons about the difficulty of undertaking reform and the need for effectiveness,

flexibility, and steadfastness. Effectiveness involves collecting the data necessary to assess impact—separating the transitory from the permanent and the trivial from the important. Flexibility is critical to make changes and refinements when conditions warrant and when actual outcomes differ substantially from the expected ones. Steadfastness is needed when particular interests pit the primacy of their needs against the more global interest of making Medicare affordable, sustainable, and effective for current and future generations of Americans. This makes it all the more important that any new benefit expansion be carefully designed to balance needs and affordability both now and over the longer term.

The bottom line is that surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs, but an obligation to do so in a way that improves the prospects for future generations. This generation has a stewardship responsibility to future generations to reduce the debt burden they inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the cohort of workers 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 needed become dramatic and disruptive. The prudent use of the nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

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

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