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MEDICARE REFORM

Modernization Requires Comprehensive Program View

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you continue to consider how the Medicare program might be modified to better serve beneficiaries, providers, and taxpayers. Discussions about how to reform and modernize Medicare have, in part, focused on whether the structure that was adopted in 1965 remains optimal today. In that context, questions have been raised about the desirability of maintaining Medicare's division into two distinct parts, part A for hospital and other institutional care and part B for physician, outpatient, and other noninstitutional services. This bifurcated structure is no longer common among private insurance, as it was in the 1960s when insurers marketed separate policies for different services.

Problems with financing, beneficiary cost-sharing, and program management have been linked with the fragmented structure of the program. Yet merging parts A and B may not be the only way to make progress in addressing these problems. To assist the Subcommittee as it considers restructuring Medicare, my remarks today focus on how reforms based on a more unified view of the program might affect (1) program financing and assessment of the program's financial health, (2) cost sharing requirements, and (3) program management, including administration and promotion of quality care. These observations are based on previous and ongoing GAO work on Medicare and private sector insurance, as well as other published research.

In summary, rethinking the relationship between parts A and B may encourage use of a more comprehensive measure of Medicare's financial health. The commonly used measure, part A trust fund solvency, does not include the growing share of program spending on part B services. While a more complete picture of Medicare's financial health can be obtained in a number of ways, the desire for a better picture of the program's financial prognosis is one argument for a single trust fund. Establishing a single trust fund would require agreement on how funds from payroll taxes, general revenues, and beneficiary premiums would flow to the program. It would require consensus on what measure would be used to track program finances and spur action to increase revenue or curb spending when needed. It also would require assessment of whether different beneficiary eligibility standards, similar to those currently specified for parts A and B, would be maintained.

Rethinking the relationship between parts A and B also could facilitate development of better cost-sharing requirements. The current cost-sharing structure fails to promote prudent use of services and protect beneficiaries

from high out-of-pocket costs. These concerns could be addressed under the current part A and B structure or a more unified structure. Unifying the program completely would require some beneficiaries who now have other coverage and are enrolled in only one part of the program to pay additional premiums for coverage they already have. It also would increase costs to the government for care that is now covered privately. Alternatively, partial benefits could be extended to those who chose not to fully participate in a unified program.

Rethinking the relationship between parts A and B would not fundamentally address challenges the Health Care Financing Administration (HCFA) faces in efficiently managing the disparate services Medicare covers. HCFA's outdated information technology (IT) systems have hindered its ability to develop data to improve payment methods and the quality of care beneficiaries receive. Further, as a large public program, Medicare is limited in its ability to incorporate innovations that private insurers have used to influence care delivery. These include targeted beneficiary education, preferred provider networks, and coordination of services. The National Academy of Social Insurance (NASI) has reviewed these private sector practices and concluded that they could potentially improve Medicare. However, they would need to be tested to determine their impacts and evaluated to ascertain how well they might be adapted to reflect the uniqueness of Medicare as both a public program and the largest single purchaser of health care. Full implementation of many of these innovations would require statutory changes to the program.

Background

At its inception, Medicare's design mimicked the structure of existing private insurance, which commonly included different policies for different sets of services. It also was designed, like private insurance at the time, as a passive bill payer that did not try to influence how care was delivered. In fact, because of concerns about the potential influence of such a large government program, the original Medicare statute requires that Medicare not influence providers' practice of medicine and gives beneficiaries access to all participating providers.

Medicare is administered by the HCFA, and pays for some $200 billion in health care benefits each year for about 40 million elderly and disabled Americans. Individuals who are eligible for Medicare automatically receive Hospital Insurance (HI), known as part A, which covers inpatient hospital, skilled nursing facilities (SNF), certain home health, and hospice care. Beneficiaries generally pay no premium for this coverage, having

previously contributed payroll taxes from covered employment, but they are liable for required deductibles, coinsurance, and copayment amounts. (See tables 1 and 2.)

Medicare-eligible beneficiaries may elect to purchase Supplementary Medical Insurance (SMI), known as part B, which covers physician, outpatient hospital, laboratory, and other services. Beneficiaries must pay a premium for part B coverage, currently $50 per month, and are also responsible for part B deductibles, coinsurance, and copayments.

Most of Medicare's 40 million beneficiaries are enrolled in both parts A and B. However, approximately 2 million are enrolled only in part A. Another 400,000 are enrolled only in part B. Those enrolled in only one part of the program often have private insurance from an employer or other source to make up the difference.

Approximately 14 percent of Medicare beneficiaries enroll in Medicare+Choice plans. These plans include health maintenance organizations and other private insurers who are paid a set amount each month to provide all Medicare-covered services. Beneficiaries must be enrolled in both parts A and B to join these plans, which typically offer lower cost-sharing requirements and additional benefits compared to Medicare's traditional fee-for-service program, in exchange for a restricted choice of providers.

Table 1: Medicare Part A and Part B Coverage, Eligibility, and Funding

	Part A	Part B
Coverage	-Inpatient hospital. -Skilled nursing facility (SNF). -Home health.[a] -Hospice.	-Physician services. -Laboratory services. -Outpatient hospital. -Home health.[a] -Durable medical equipment
Eligibility	-Individuals and their spouses over 65 who paid the Medicare payroll tax for 10 years (40 quarters). -Individuals over 65 who paid the Medicare payroll tax for 30 to 39 quarters and who pay a $165 monthly premium. -Individuals over 65 who paid the payroll tax for less than 30 quarters and who pay a $300 monthly premium. -Individuals eligible for Social Security disability benefits. -Individuals with end-stage renal disease.	-Individuals over age 65, disabled, or with end-stage renal disease who pay a monthly premium ($50 in 2001).
Funding	Medicare payroll taxes.	Premiums cover 25 percent and general tax revenue covers 75 percent.

[a]Part A covers up to 100 home health visits following an inpatient hospital or SNF stay. Part B covers other home health visits.

Source: Medicare & You 2001, HCFA.

Table 2: Medicare Beneficiary Cost-Sharing for 2001

Part A services:	**Copayments, coinsurance, and deductibles:**
Inpatient hospital	$792 deductible per admission[a] $198 copayment per day for days 61 through 90 $396 copayment per day for days 91 through 150[b] All costs beyond 150 days
Skilled nursing facility (SNF)	No cost-sharing for first 20 days $99 per day copayment for days 21 through 100 All costs beyond 100 days
Home health	No cost-sharing 20 percent coinsurance for durable medical equipment
Hospice	$5 copayment for outpatient drugs 5 percent coinsurance for inpatient respite care
Part B services[c]:	
Physician and medical	$100 deductible each year 20 percent coinsurance for most services 50 percent coinsurance for mental health services
Clinical laboratory	No cost-sharing
Home health	No cost-sharing 20 percent coinsurance for durable medical equipment
Outpatient hospital	Coinsurance varies by service and may exceed 50 percent

[a]No deductible is charged for second and subsequent hospital admissions if they occur within 60 days of the beneficiary's most recent covered inpatient stay.

[b]After the first 90 days of inpatient care, Medicare may help pay for an additional 60 days of inpatient care (days 91 through 150). Each beneficiary is entitled to a lifetime reserve of 60 days of inpatient coverage. Each reserve day may be used only once in a beneficiary's lifetime.

[c]No cost-sharing is required for certain preventive services—including specific screening tests for colon, cervical, and prostate cancer and flu and pneumonia vaccines.

Source: Medicare & You 2001, HCFA.

Medicare pays for services out of two separate trust funds. Part A services are paid for out of the HI Trust Fund. It is primarily financed through the Medicare payroll tax that is exclusively dedicated to this trust fund. Part B services are paid for out of the SMI Trust Fund. This trust fund is financed in part through the part B premium, which is adjusted each year to equal 25 percent of expected part B spending. The remaining 75 percent is paid for out of general tax revenues.

Restructuring Raises Financing and Beneficiary Participation Issues

Medicare's two parts have distinct financing and participation arrangements. Modifying these arrangements could promote the use of a more comprehensive measure of Medicare's financial health and help policymakers anticipate future fiscal imbalances. In addition to selecting such a measure or measures, Congress could also decide to establish thresholds that would trigger corrective actions designed to rebalance Medicare revenues and spending. Unification of the now separate HI and SMI trust funds would require consideration of these issues, but even without such a merger, comprehensive financial measures and associated triggers would be useful. Unification would also require Congress to determine how the current mix of payroll taxes, beneficiary premiums, and general revenues might be modified to fund the program, as well as whether beneficiaries would be obligated to participate in the full program or could obtain coverage for subsets of services.

Focus on HI Trust Fund Provides Misleading View of Medicare's Financial Health

In the past, Medicare's financial status has been generally gauged by the projected solvency of the HI trust fund. Looked at this way—and based on the latest annual report from the Medicare Trustees—Medicare is viewed as solvent through 2029. Solvency is a popular measure, in part because the consequences of insolvency are clear. If there is no money in the HI trust fund, the government cannot pay hospitals or other providers of part A services. Thus, the threat of insolvency can be a powerful driver for action. In 1997, the Medicare Trustees estimated that the HI trust fund would become insolvent in 2001. The HI trust fund had not been so close to a crisis since 1972. Following the Trustees' 1997 report, Congress enacted the Balanced Budget Act of 1997, which contained substantial payment and other reforms designed to slow Medicare's cost growth. These reforms, coupled with a strong economy, helped to increase the life expectancy of the HI trust fund.

However, HI trust fund solvency is an incomplete measure of Medicare's fiscal health. It does not reflect the cost of the part B component of Medicare, which covers outpatient services and is financed through general revenues and beneficiary premiums. Part B accounts for more than 40 percent of current Medicare spending and is expected to account for a growing share of future total program dollars. The concept of solvency does not apply to the trust fund for part B, SMI, because increases in expenditures are automatically matched with increases in general revenues and beneficiary premiums.

In addition, HI trust fund solvency does not mean that Medicare's part A component is financially healthy. Although the trust fund is expected to

remain solvent until 2029, HI outlays are projected to exceed HI revenues beginning in 2016. As the baby boom generation retires and the Medicare-eligible population swells, the imbalance between outlays and revenues will increase dramatically. Thus, in 15 years the HI trust fund will begin to experience a growing annual cash deficit. At that point, the HI program must redeem Treasury securities acquired during years of cash surplus. The government will then need to increase taxes, increase borrowing (or retire less debt), impose spending cuts, or implement some combination of these actions.

When part A expenditures outstrip payroll tax revenues, it may be tempting to reallocate some expenditures from part A to part B. This would extend the solvency of the HI trust fund, but would do little to improve Medicare's overall financial health. For example, BBA reallocated a portion of home health spending from part A to part B. Although that action—phased in over time—reduces HI expenditures and extends that trust fund's solvency, it also increases SMI expenditures. Consequently, the home health reallocation increases the proportion of Medicare funded by general revenues and beneficiary premiums.

Comprehensive Measures Could Better Indicate Program Sustainability

Clearly, it is total program spending—both part A and part B—which determines whether Medicare is sustainable over the long haul. Whether the program remains in its current configuration, or the relationship between parts A and B are restructured, a more comprehensive measure of Medicare's financial health could help Congress anticipate future fiscal imbalances. A variety of such measures exist now. For example, the Medicare Trustees report total Medicare spending as a share of gross domestic product (GDP). This measure clearly shows that total Medicare expenditures will likely consume an increasingly larger share of the national economy. Currently, combined HI and SMI expenditures account for 2.3 percent of GDP. This percentage is expected to rise to 4.5 percent in 2030 and 8.5 percent in 2075. Another comprehensive indicator measures Medicare spending relative to the entire federal budget. We estimate that Medicare's share of the federal budget will increase from 10 percent in 2000 to over 23 percent in 2030 if the program's spending growth continues unchecked.[1]

[1] *Medicare: Higher Expected Spending and Call for New Benefit Underscore Need for Meaningful Reform* (GAO-01-539T, Mar. 22, 2001).

Fiscal Measures Could Trigger Congressional Action

The adoption of new financial health indicators for Medicare would be one step; the next would be to decide what should trigger congressional action. Congress could agree that it would take action to rebalance Medicare spending and revenues whenever a comprehensive measure reached a predetermined level. Possible actions could include increasing general revenue contributions, payroll taxes, or beneficiary premiums; reducing benefits; cutting provider payments; or introducing efficiencies to moderate spending. The 1999 Breaux-Frist Medicare reform proposal provides one example of a potential trigger. Under that proposal, the two trust funds would be unified and congressional action would be required in any year when general revenue contributions exceeded 40 percent of total Medicare expenditures.

The need for measures of program sustainability and thresholds that would trigger congressional action would be most acute if the trust funds are unified. Such a reconfiguration could remove the powerful signal of the HI trust fund insolvency and reduce the apparent urgency of corrective actions. If the trust funds remain separate, comprehensive measures of Medicare's financial health and associated triggers could avoid the shortcomings that arise from a focus on the HI trust fund's solvency.

Improved measures of Medicare sustainability and agreed-upon thresholds will not, however, alter the difficult decisions facing this and future Congresses. A growing Medicare population and advances in expensive medical technology will increase future demands for health care spending. Policymakers will need to find ways either to control Medicare's spending growth or obtain additional revenues to pay for it. Any solution to address the financial imbalance will affect beneficiaries, taxpayers, providers, or some combination of the three groups. Better measures of Medicare's financial health may help identify the need for action, but will not lessen the difficulty of implementing a solution.

Unification of Trust Funds Raises Questions About Financing, Premiums, and Participation

Creating a unified trust fund for Medicare parts A and B would raise several new issues Congress would need to address. One is program financing—Congress would have to specify Medicare's revenue sources and the share that each source would contribute. Under the current arrangement, revenues come from the Medicare payroll tax, general revenues, and beneficiary premiums. Broadly speaking, the amount financed from each revenue source depends upon the amount spent on Medicare services and the classification of services into parts A and B. The payroll tax supports part A services. The amount of general revenues

devoted to Medicare is set equal to 75 percent of part B expenditures. Beneficiary premiums are collected to pay for the remaining 25 percent of part B spending. If the trust funds were unified, Congress would have to specify the funding mechanism. It could, for example, determine the share that general tax revenues, payroll tax revenues, and beneficiary premiums would each contribute to total Medicare spending. Alternatively, it could adopt an allocation formula similar to the present one by designating some services to be supported by the payroll tax and others to be supported by general revenues and beneficiary premiums.

Beneficiary participation issues would also arise under a restructured program with a unified trust fund. Currently, about 2 million individuals (5 percent of beneficiaries) are eligible for Medicare part B but do not participate in the voluntary program. A smaller number of individuals do not qualify for coverage under part A, although provisions allow certain individuals to buy into the program by paying a monthly premium. Under a restructured program, Congress would need to determine beneficiary participation and premium options. For example, should participation in the full program and payment of any associated premium be mandatory? If full participation is mandated, program costs could increase and some beneficiaries would receive Medicare coverage for services covered by existing private policies. If full participation is voluntary, what coverage should be provided to those individuals who choose less than full participation? Would individuals who had made payroll tax contributions but decline to pay the premium not receive coverage? Or would reduced benefits—for example, coverage only for current part A services—be available for such individuals?

Beneficiary Cost-Sharing Could Be Improved

Rethinking the relationship between parts A and B could facilitate rationalization of cost-sharing requirements and help make Medicare more like private sector and Medicare+Choice plans. Medicare's benefit design has changed little since its inception 35 years ago, and in many ways has not kept pace with changing health care needs and private sector insurance practices. Medicare's current cost-sharing requirements in particular are not well structured to promote prudent use of discretionary services. At the same time, they can create financial barriers to care and

leave beneficiaries with extensive health care needs liable for high out-of-pocket costs.[2]

Cost-Sharing Requirements Are Not Well Structured

Health insurers today commonly design cost-sharing requirements—in the form of deductibles, coinsurance, and copayments—to ensure that beneficiaries are aware there is a cost associated with the provision of services and to encourage them to use services prudently. Ideally, cost-sharing should encourage beneficiaries to evaluate the need for discretionary care but not discourage necessary care. Optimally, cost-sharing would generally require coinsurance or copayments for services that may be discretionary and could potentially be overused, and would also aim to steer patients to lower cost or better treatment options. Care must be taken, however, to avoid setting cost-sharing amounts so high as to create financial barriers to necessary care.

The benefit packages of most Medicare+Choice plans illustrate cost-sharing arrangements that have been designed to reinforce cost containment and treatment goals. Most Medicare+Choice plans charge a small copayment for physician visits ($10 or less) and emergency room services (less than $50). Relatively few Medicare+Choice plans charge copayments for hospital admissions. Plans that offer prescription drug benefits typically design cost-sharing provisions that encourage beneficiaries to use cheaper generic drugs or brand name drugs for which the plan has negotiated a discount.

Medicare fee-for-service cost-sharing rules diverge from these common insurance industry practices in important ways. For example, as indicated in table 2, Medicare imposes a relatively high deductible of $792 for hospital admissions, which are rarely optional. In contrast, Medicare requires no cost-sharing for home health care services, even though historically high utilization growth and wide geographic disparities in the use of such services have raised concerns about the potentially discretionary nature of some services.[3] Medicare also has not increased the part B deductible since 1991. For the last 10 years the deductible has

[2]*Medicare: Cost Sharing Policies Problematic for Beneficiaries and Program* (GAO-01-713T, May 9, 2001).

[3]See *Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available* (GAO/HEHS-00-9, Apr. 7, 2000).

remained constant at $100 and has thus steadily decreased as a proportion of beneficiaries' real income.

Beneficiary Liability Is Unlimited

Also unlike most employer-sponsored health plans for active workers, Medicare does not limit beneficiaries' cost-sharing liability. Employer-sponsored plans typically limit maximum annual out-of-pocket costs for covered services to less than $2,000 per year for single coverage.[4] In Medicare, however, current estimates suggest that the combination of cost-sharing requirements on covered services and the cost of services not covered by Medicare leaves beneficiaries liable for about 45 percent of their health care costs. The average beneficiary is estimated to have incurred about $3,100 in out-of-pocket expenses for health care in 2000—an amount equal to about 22 percent of the average beneficiary's income.[5] Some beneficiaries face much greater financial burdens. For example, low-income single women over age 85 in poor health and not covered by Medicaid are estimated to have spent more than half (about 52 percent) of their incomes on health care services.[6]

The average beneficiary who obtained services had a total liability for Medicare-covered services of $1,451, consisting of $925 in Medicare copayments and deductibles in addition to the $526 in annual part B premiums in 1997, the most recent year for which data are available on the distribution of these costs. The burden of Medicare cost-sharing can, again, be much higher for beneficiaries with extensive health care needs. In 1997 slightly more than 3.4 million beneficiaries (11.4 percent of beneficiaries who obtained services) were liable for more than $2,000. Approximately 750,000 of these beneficiaries (2.5 percent) were liable for more than $5,000, and about 173,000 beneficiaries (0.6 percent) were liable for more than $10,000.

Options for Addressing Cost-Sharing Concerns

Different approaches could be taken to address concerns about current cost-sharing requirements. Cost-sharing for less discretionary services could be reduced or eliminated. Catastrophic protection could be added to

[4]The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey*.

[5]Stephanie Maxwell, Marilyn Moon, and Mesha Segal, *Growth in Medicare and Out-Of-Pocket Spending: Impact on Vulnerable Beneficiaries* (Urban Institute, Dec. 2000).

[6]Maxwell, Moon, and Segal.

the benefits package. In addition, the part B deductible could be raised, or the part A and B deductibles could be combined.

Reducing or eliminating cost-sharing for less discretionary services, such as inpatient hospital care, could be done within the current program structure. Congress has already taken similar action by reducing and eliminating cost-sharing requirements for various cancer screening tests and vaccinations in order to ensure that affordability is not a barrier to these important services.

Adding catastrophic protection by capping how much beneficiaries are required to pay out-of-pocket also could be done under current program structure. There would need to be agreement on how to allocate between parts A and B the added cost to the program and recognition of the time and resources needed to incorporate such a change into HCFA's information systems.

Raising the part B deductible or creating a combined deductible for part A and part B services has been suggested to offset some of the additional cost of providing catastrophic protection. It would also offset some of the real-dollar decline in the part B deductible, which has not been adjusted for inflation or raised in any way since 1990. These changes could be done under current program structure as well, again with recognition of the time and resources needed to incorporate the change into HCFA's information systems. Most beneficiaries who incurred cost-sharing would likely meet a combined deductible through their use of what are now part B services. If the combined deductible is set higher than the current part B deductible, providing protection for low-income beneficiaries so that costs do not become a barrier to needed services or an undue burden would be an important consideration.

Combining the deductible or providing catastrophic protection would again raise the issue of whether to maintain individuals' ability to participate independently in A or B or to require full participation by all beneficiaries in the entire program. Requiring full participation for beneficiaries who now participate in only one part of the program could result in additional costs for beneficiaries who have alternative coverage as well as additional program costs. It also raises the issue of the entitlement for persons who have paid the required payroll tax, but choose not to pay the premium.

Partial benefits could be extended to those who do not fully participate in the program. Alternatively, some of the effects of mandatory participation

could be muted by phasing in a unified program so that new beneficiaries would participate in the full program while those who now participate in only part of the program could continue to do so.

Challenges for Management and Promoting Care Quality Remain Regardless of Restructuring

As noted earlier, the original Medicare statute reflected 1960s private health insurance practices that often included separate policies for different services as well as a passive bill paying approach. In contrast to Medicare, which has not changed much since its inception, private insurance has evolved over the last 40 years and now offers comprehensive policies and employs management techniques designed to improve the quality and efficiency of services purchased. Private insurers are able to undertake these efforts because many have detailed data on service use across enrollees and providers, as well as wide latitude in how they run their businesses. Regardless of whether the relationship between parts A and B is restructured, HCFA faces challenges in seeking to more efficiently manage Medicare services due to its outdated and inadequate IT systems, statutory constraints, and the fundamental need for public accountability that accompanies a large public program. These limitations have hampered the agency's ability to administer the program and incorporate new innovations. Private insurers have taken steps to influence utilization and patterns of service delivery through efforts such as beneficiary education, preferred provider networks, and coordination of services. NASI has reviewed many of these private sector activities and concluded that they could have potential value for Medicare. However, they would need to be tested to determine their effects as well as how they might be adapted to reflect the uniqueness of Medicare as both a public program and the largest single purchaser of health care. In addition, HCFA would likely need new statutory authority to broadly implement many of these innovations.

Effective Program Management Depends on Comprehensive and Timely Information

To effectively oversee claims administration and assess the effects of innovative policies that private sector insurers have adopted, HCFA needs timely and comprehensive information on services and payments in the aggregate and for individual beneficiaries. HCFA lacks that capacity today, not because it has separate contractors for parts A and B, but because of deficiencies in its information systems. Some of the agency's vital information systems are decades old, with some operating software rarely used today by any entity other than HCFA, and lack the capacity and flexibility that newer technology can offer. Consequently, HCFA has had difficulty assembling timely and comprehensive information about provider billing patterns and beneficiary service use.

Currently, data from parts A and B do flow to some common points—both during claims processing and after. During claims processing, both part A and part B claims are checked through a prepayment validation and authorization system operated by HCFA—the Common Working File (CWF). Claims approved for payment are ultimately complied in the National Claims History (NCH) file, which can be analyzed to look at broader payment trends within the program. The problem is that this compilation of information occurs long after services have been delivered and claims paid.

These system limitations are unfortunate because changes in Medicare payment policy for one type of service can have reverberations in other areas. To understand these effects requires analysis across a range of services beneficiaries may be receiving. A clear example of this occurred after the implementation of a prospective payment system (PPS) for hospitals, which pays hospitals fixed, predetermined amounts for each hospital stay that vary according to patients' diagnoses. Prior to this innovation, hospitals were paid on the basis of their costs, with little incentive to limit patient stays or provide care efficiently. Paying a fixed amount for an episode of hospital care creates incentives for hospitals to reduce lengths of stay and to shift services that had been provided in the hospital to other settings. Understanding these modifications in care delivery led to payment changes to prevent Medicare from paying twice for the same service. More recent payment changes for home health and SNF services, and the soon to be implemented PPS for inpatient rehabilitation services, will likely cause similar kinds of care shifts. It is essential that HCFA has the ability to monitor changes in care delivery in a timely and objective manner to determine how these payment policies may need to be adjusted in the future.

Recent experience has also demonstrated HCFA's difficulties in developing information to measure the effects of changing Medicare policies on beneficiaries and providers in a comprehensive and timely manner. The Balanced Budget Act of 1997 (BBA) payment reforms represented bold steps to control Medicare spending by changing the financial incentives for delivering care efficiently. Reforms affected hospitals, home health agencies, SNFs, and providers of other services. Affected providers presented anecdotal evidence asserting that the BBA's payment reforms caused them financial difficulties and would impair beneficiary access, urging Congress to undo some of the act's provisions. HCFA analysts were ill-equipped to assess the validity of these charges because the necessary program data were not readily available.

Better and more timely information is a prerequisite to more effective program management. It is essential to the development and refinement of payment methods for different service providers. It can also help policymakers understand the desirable and undesirable consequences of changes on beneficiaries, providers, and the trust funds. Generating these data is not dependent on unifying part A and part B, but rather on merging part A and part B data in a modern information system capable of supporting timely, pertinent analyses.

Quality Promotion Efforts Could Reap Benefits but Face Many Obstacles

An expert panel convened by NASI has suggested that Medicare may benefit from moving away from its passive bill paying approach by adopting some private insurers' practices designed to improve the quality and efficiency of care.[7] The panel focused on provider and beneficiary education, preferred provider networks, and coordination of services as potential improvements in Medicare. Educating beneficiaries or providers could improve the use of important preventive and other services currently being underused and minimize questionable use of services. Developing a system of preferred providers selected on the basis of quality as well as cost could improve care and help achieve savings. More actively coordinating care across provider settings for beneficiaries with chronic diseases like diabetes or who have recently experienced heart attacks might also help improve quality and efficiency. HCFA has begun to implement some innovations and experiment with others. Broadly implementing the experimental innovations that prove successful may require new statutory authority. Other private sector innovations, however, may be difficult to incorporate, given Medicare's size and the need for transparency in a public program.

HCFA has been able to implement broad-based education efforts but has been stymied in implementing approaches targeted to individual beneficiaries most likely to need the help. For example, it has an extensive effort underway to encourage colon cancer screening that includes dissemination of more than 23,000 innovative posters. The posters include tear-off sheets that beneficiaries can hand to physicians to facilitate discussions that otherwise might be avoided because of the unfamiliar words, sensitive issues, and unpleasant options that can be involved.

[7] *From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare,* Final Report of the Study Panel on Fee-for-Service Medicare, National Academy of Social Insurance, Washington, D.C.: January 1998.

HCFA is also involved in a multifaceted effort to increase flu vaccinations and mammography use among beneficiaries. However, HCFA may be less able to undertake more targeted education efforts that some private insurers are using, such as sending out reminders to identified enrollees about the need to obtain a certain service. Because of Medicare's size and status as a federal program, beneficiaries and others might have concerns about HCFA using personal medical information from claims data to target educational efforts. Providers might also object to a government insurance program advocating certain medical services for their patients.

HCFA is providing more information to physicians about service use and typical practice patterns in an effort to educate them about how their practice patterns compare to the norm. For example, the Medicare peer review organizations encourage those who have unusual practice patterns to reconsider their service provision. However, private insurers can go one step further and terminate providers who continue to have aberrant practice patterns. HCFA's ability to terminate providers is much more limited because of statutory requirements intended to protect beneficiaries' choice of providers.

HCFA's ability to encourage use of preferred providers is also limited. The Medicare statute generally allows any qualified provider to participate in the program. HCFA has experimented with bundling payments for certain expensive procedures performed by designated providers. For example, it tested the impact of making single "global" payments to hospitals for all services–both hospital and physician—related to coronary artery bypass graft surgery. The hospitals chosen for the experiment were among those with the best outcomes for these surgeries.[8] The experiment cut program costs by 10 percent for the 10,000 coronary artery bypass surgeries performed, and saved money for beneficiaries through reduced part B coinsurance payments. More important, compared to a group of beneficiaries not receiving this bundled care, beneficiaries who were treated in one of the selected hospitals had lower mortality rates, were more satisfied with the quality of the nursing care, and appreciated the simplicity of a single coinsurance amount. HCFA has begun a similar experiment at selected acute care hospitals, which involves bundling payments for hospital, physician, and other health care professionals'

[8]A number of studies prior to this experiment have found that hospitals with the greatest volume of these types of surgeries generally had better outcomes, in regard to mortality and complications.

services provided during a beneficiary's hospital stay for selected cardiovascular and orthopedic procedures.

However, more wide scale Medicare implementation of such hospital and physician partnership arrangements may be difficult. Providers have raised concerns about a government program designating some providers as delivering higher quality care than others. In addition, bundling services for hospitals and doctors added administrative burdens to the hospitals and took control of payments away from doctors. In the end, it is not the separation of parts A and B that would impede efforts to promote such preferred provider arrangements. Rather, it may be more deep-seated concerns about government promotion of certain providers at the expense of others that serve as a barrier to this and other types of preferred provider arrangements.

HCFA has also been conducting demonstrations to test how to better coordinate care for certain patients since the 1980s. In addition, BBA[9] mandates that HCFA find budget neutral ways to test methods of coordinating a range of services for chronically ill beneficiaries in at least nine urban and rural sites. The law authorizes the Secretary of Health and Human Services to incorporate any components proven to be cost-effective into Medicare through regulations and to expand the number of demonstration sites.

While there is increasing interest in efforts to coordinate care, it is not clear that they are always cost-effective. Some experience in both the private and public sectors suggests that such efforts can improve quality and achieve savings. For example, the Group Health Cooperative of Puget Sound and PacifiCare teamed with a senior citizens center to offer supervised health promotion and chronic illness self-management interventions to chronically ill seniors. The intervention included meetings with geriatric nurse practitioners to develop individually tailored health promotion plans, medication reviews, classes, support groups, and volunteer mentors. Preliminary findings suggested that the case-managed group had fewer health problems and lower costs compared to a group that did not receive the services. However, other experiments, including those conducted by HCFA, have failed to demonstrate either quality improvements or cost savings. Furthermore, there would need to be statutory changes to implement different coordination approaches in

[9]Section 4016.

Medicare if they involved coverage of new services, such as care coordinators, or involved control over the use of particular services or providers.

Concluding Observations

The Medicare program faces many challenges. Clearly, the overarching issue is how to ensure that Medicare remains sustainable for future generations of beneficiaries. Meeting that challenge will involve difficult decisions that will likely affect beneficiaries, providers, and taxpayers. However, the financing issue should not obscure other important Medicare challenges. Medicare's current cost-sharing arrangements are not well designed to encourage the efficient use of services without discouraging necessary care. Moreover, the lack of catastrophic coverage can leave some beneficiaries liable for substantial Medicare expenses. Finally, some aspects of Medicare's program management are inefficient and lag behind modern private sector practices. Changes in Medicare's program management could improve both the delivery of health care to beneficiaries and the program's ability to pay providers appropriately.

Some view restructuring of the relationship between parts A and B as an important element of overall Medicare reform. Fundamentally, assessing the program as a whole is an important first step in addressing Medicare's challenges. Solutions to many of these challenges could be crafted without restructuring. However, restructuring may provide opportunities to implement desired reforms—with or without unifying the HI and SMI trust funds—while undoubtedly raising issues that will have to be considered.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or members of the Subcommittee may have.

GAO Contacts and Staff Acknowledgments

For more information regarding this testimony, please contact me or Laura Dummit at (202) 512-7114. Sheila Avruch, James Cosgrove, and Paul Cotton also made key contributions to this statement.

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