STRENGTHENING MEDICARE FOR FUTURE GENERATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

SEPTEMBER 22, 1999

Serial 106–48

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
65–698 CC WASHINGTON : 2000

For sale by the U.S. Government Printing Office,
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402

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STRENGTHENING MEDICARE FOR FUTURE GENERATIONS

WEDNESDAY, SEPTEMBER 22, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:07 p.m., in room 1100, Longworth House Office Building, Hon. William M. Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 9, 1999
No. HL–9

CONTACT: (202) 225–3943

Thomas Announces Hearing on the Strengthening Medicare for Future Generations

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on strengthening the Medicare program for future generations. The hearing will take place on Thursday, September 16, 1999, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include experts in the structure, financing and history of the Medicare program. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

In the years ahead, the Medicare program will face serious challenges brought on by rapid changes in the aging of the population and increasing medical costs. Today, Medicare comprises 11 percent of Federal outlays, but by 2030, it is projected to consume between 28 and 38 percent of Federal spending, requiring more than doubling the payroll tax to cover increased expenditures. Even sooner, without structural changes in the program, Medicare will be bankrupt by 2015.

Additionally, Medicare has not kept pace with the transformation of the health care delivery system. While the program represented first-class coverage in 1965, private insurance plans have surpassed Medicare in offering their enrollees better benefits, including prescription drug coverage, and greater choice of providers at reduced cost. The National Bipartisan Commission on the Future of Medicare considered these facts in indicating its support for a plan to strengthen and improve the Medicare program in time for the retirement of the 77 million "Baby Boomers" beginning in 2010.

In announcing the hearing, Chairman Thomas stated: "The Medicare Commission's proposal received bipartisan support from 60 percent of its members. I believe that the Commission's approach, based on expanded choice for all beneficiaries in all areas, improved benefits, and increased efficiencies, offers the best plan for sustaining the Medicare program for future generations. As Congress deliberates the best methods to strengthen Medicare and expand benefits to include prescription drugs for needy seniors, we must act in a comprehensive way that will not bankrupt Medicare and deny seniors their current benefits. Medicare's current statutory and regulatory structure simply cannot keep pace with innovations in the health care delivery system."

FOCUS OF THE HEARING:

The hearing will focus on the need to reform the administration, structure, and financing of the Medicare program to maintain its long term solvency, ensure enrollees' access to benefits, and improve choice of health plans.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, with their name, address, and hearing date noted on a label, by the close of business, Thursday, September 30, 1999, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

NOTICE—CHANGE IN TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 13, 1999
No. HL–9-Revised

CONTACT: (202) 225–3943

Change in Time for Subcommittee Hearing on Strengthening Medicare for Future Generations Thursday, September 16, 1999

Congressman Bill Thomas (R–CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on strengthening Medicare for future generations, previously scheduled for Thursday, September 16, 1999, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will now begin at 1:30 p.m.**

All other details for the hearing remain the same. (See Subcommittee press release No. HL–9, dated September 9, 1999.)

NOTICE—HEARING POSTPONEMENT

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 15, 1999
No. HL–9-Revised

CONTACT: (202) 225–3943

Postponement for Subcommittee Hearing on Strengthening Medicare for Future Generations Thursday, September 16, 1999

Congressman Bill Thomas (R–CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on strengthening Medicare for future generations, previously scheduled for Thursday, September 16, 1999, at 1:30 p.m., in the main Committee hearing room, 1100 Longworth House Office Building, **has been postponed until Wednesday, September 22, 1999, beginning at 2:00 p.m.**

All other details for the hearing remain the same. (See Subcommittee press release No. HL–9 , dated September 9, 1999.)

Chairman THOMAS. The Subcommittee will please come to order. I want to thank everyone for allowing the week to lapse, and especially those witnesses who were inconvenienced in terms of I know very busy schedules.

Today hopefully we will do a little bit of discussing about Medicare and the way it should be. There is no question that the Medicare Program has improved the health and has provided security to millions of seniors since its inception in 1965.

Thirty-five years ago Medicare was modeled on what was then state-of-the-art health care insurance. The program was based on acute hospital care, offered no real preventive benefits, and provided the then going model of cost reimbursement. However, it is obvious that the evolving health care delivery, shifting demographics, advanced technology, all structured into rising health care costs, are threatening the Medicare Program, without change.

Medicare's current statutory and regulatory structure has not been able to keep pace with the changes in the health care marketplace. Seniors are often not afforded the choices of health care that Members of Congress and most Americans enjoy. It wasn't until 1997 that a really meaningful preventive and wellness package was even included, and there it fell far short in many areas.

Seniors do not benefit from the availability of the most innovative and advanced treatments. In addition, income tax payers have been called upon to shoulder an increasing share of the program's financing. Providers are almost literally crushed under the 130,000 pages of minutely detailed rules and regulations. Increasingly, policymakers are calling for a structure that offers solutions.

As all of us now know, 10 of the 17 members of the National Bipartisan Commission on the Future of Medicare—which was about a 60 percent majority, but given the rules under the statute, it had to be a super, super, supermajority—thought a market-based structure would provide the solution for reforming a significant portion of the seniors' health program.

The term that was utilized was "premium support," and it modernized Medicare by integrating innovations of the marketplace into the program and harnessing competition to control costs, while preserving the entitlement, the specific defined benefits, and the safety net. Structural reform of Medicare, many of us believe, is the best way to ensure that seniors get the added health benefits they need, such as prescription drug coverage, while also guaranteeing Medicare will meet the health care needs of the Nation's retiring 77 million baby boomers.

There are a lot of myths about premium support, and I hope that some of them will not be perpetuated today. We do want to look at other options and focus on proposals that are constructive for fundamental reform.

I am particularly heartened that the President has delivered on his promise of those many months ago, that he would provide a proposal. And interestingly, when you look at some of the President's proposal, there is a degree, at least as they perceive it, of competition in the President's model as defined, to provide more choice for seniors.

In the House, we are working with a bipartisan group to further refine that concept of premium support, but all of us obviously are still looking for any new ideas or innovations that can make Medicare work better, and preferably at a cheaper price.

We can better integrate Medicare benefits under a single comprehensive package which would allow for more rapid access to new benefits and technology. Clearly, I think most people believe that we can improve Medicare's administrative structure so that choices are not just available to some but available to all seniors.

And, finally, I think we can make the program more efficient through a better structured incentive arrangement for health plans to offer seniors higher quality care at competitive premium prices, and for seniors, to make the "right kinds of choices available to them."

I look forward to hearing the witnesses, but prior to that, it will be my pleasure to recognize the Ranking Member on the Subcommittee, the gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. I would like to yield for an opening statement to the gentleman from Washington, Mr. McDermott.

Chairman THOMAS. Let the Subcommittee say first of all, welcome back, to the gentleman from Washington.

Mr. MCDERMOTT. Good to be back, with all his moving parts working.

Chairman THOMAS. Is that kind of like it is good to be anywhere, considering the options? But, as I told you before, you look amazingly well for what has been described as to what happened to you. So would you dispel the myth that you just took a vacation, or did they really do something to you?

Mr. MCDERMOTT. I will take my shirt off and show you the scar.

I want to thank Mr. Thomas for holding this hearing and Mr. Stark for yielding me the time, and I would like permission to enter my full statement in the record.

We are having this hearing today because Medicare is the Nation's most important social health insurance program. I think it is fair to say that most everybody in this room believes it is vital to the well-being of the seniors of this country.

Since Medicare was enacting in 1965, Medicare has had an enormous impact on the quality of life of America's families by drastically increasing the number of seniors who have health care coverage. Before Medicare, only 46 percent of seniors had health insurance. Today, 99 percent do. We must never forget that basic fact when we talk about Medicare's future. So I think you can understand I get nervous when folks start talking about the magic of health care competition strengthening Medicare for the future, when before Medicare the marketplace left 54 percent of America's seniors uninsured.

The objective of Medicare reform should not be to further segment the market under the guise of competition, that is, to make it easier for insurance companies to pick off the healthiest beneficiaries as subscribers and leave the rest for the Government to take care of. The issue of market competition through the issuance of vouchers, versus the importance of maintaining a commitment to a social insurance program, was essentially the crux of the debate that Mr. Thomas referred to on the Medicare Commission, and it is why the Commission ultimately was unable to fulfill its congressional mandate.

As an aside, I would say a lot of people think we ought to have things decided by sixty and two-thirds percent and all these kind, and suddenly it turns out that maybe that is a little tougher to get done, so when you do that with taxes, you have got to remember that.

I would be naive if I did not suspect that the proposal that the Chairman will propose today looks a lot like the premium support program that was presented to the Commission. The problem is that in the 6 months since that proposal was unveiled, it still lacks sufficient detail. The concept and the proposal itself remain mostly spin and not very much substance, in my view.

In fact, in a recent memo to Mr. Stark, the HCFA actuary wrote that there is insufficient detail available regarding that proposal to permit the estimation of its financial effects. Now, I think if those details were given us, I am sure the actuary could do it.

Conversely, the President has been using the last 6 months to develop a detailed Medicare reform plan that addresses many of the holes left by the Commission; most importantly, both extends

the life of the Medicare Trust Fund beyond 20, 25, and guarantees a prescription drug benefit to all beneficiaries.

The irony is that the plan that the chairman of the Commission presented cut costs by really putting it onto the beneficiaries of Medicare. Only a small part of the cost-cutting comes from so-called premium support competition, that is, putting people in HMOs. Most of the savings comes from raising the costs on beneficiaries and cutting payments to doctors and hospitals.

Now, if there is some change, we will have to have that discussed here today. But I find it particularly hypocritical that the same people, both Democrats and Republicans, who advocate premium and by inference to extend the BBA cuts another 5 years, have been running around this Hill for the last few weeks saying that we have to give tens of billions of dollars back to the health care industry in lieu of comprehensive Medicare reform.

You cannot have it both ways. You can't talk about saving money by extending those BBA cuts on the one hand, and on the other hand have a budget process over here where we are bogged down on the HHS appropriation because we can't decide how much to give back in this process.

Radical Medicare reform that replaces the guarantee of health care with an inadequate defined contribution voucher will harm the typical Medicare beneficiary. Premium support, advanced by the leaders of the Commission, is not a solution in my view but a worsening of health care problems.

So I would like to enter into the record the dissent myself and the other Democratic Members prepared in March, detailing the failure of the Commission to meet its statutory directives to look at what it did to seniors and to the disabled, and how it would improve the long-term health of Medicare. This dissent also describes a more rational framework for reform, which I am glad to say the administration has used a number of pieces from in their proposal.

[The information had not been received at the time of printing.]

Mr. MCDERMOTT. I think it is important that the Chairman have this hearing, and I appreciate having this discussion. I think we are going to have to ultimately have this debate inside the Congress, and I applaud you for starting it, and we will have a long and interesting debate. Thank you.

[The opening statement follows:]

Statement of Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

Mr. Chairman, thank you for calling this important hearing to discuss ways to preserve and protect Medicare.

We all know we must make some changes to strengthen Medicare if it is going to be operational beyond 2015. But we need to do more than make sure the program is simply still in existence.

While Medicare is clearly a vital program in many respects for seniors today, I think we could do much more for these seniors if we introduced greater innovation into the system overall. Today, we will hear about many alterations we can make, and I am pleased that we have someone from my home state of Minnesota to talk about his proposal.

Minnesota is a leader in health care innovation, and has done many things to make our health care delivery system one of the most efficient in the country. But as the saying goes, "no good deed goes unpunished." Minnesota has been penalized for being efficient because other states have been allowed to continue with less efficient practices. Just as it is time to change a tax system that penalizes saving and marriage, it is also time to reform a health care system that penalizes efficiency.

I hear from beneficiaries from Minnesota every day who want greater equity in the system today *and* improvements for future generations. They know the problems that face Medicare are more complex and daunting, and they support comprehensive reforms sooner rather than later.

Thanks again, Mr. Chairman, for calling this important hearing. I look forward to hearing from today's witness on ways we can improve this important health care program for all those who have paid into it.

Chairman THOMAS. I thank the gentleman from Washington, and it is clearly evident he has fully recovered.

Mr. MCDERMOTT. I think I am stronger than when I went away.

Chairman THOMAS. That is the problem with this modern medicine.

Our first witness will be the director of the Congressional Budget Office, the fifth director of the Congressional Budget Office. Mr. Crippen, you have a written testimony. We will make it a part of the record, and you may address us in any way you see fit in the time allotted to you, and there may be some questions.

STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. CRIPPEN. I should hope so. Thank you, Mr. Chairman. I am pleased to be here today to discuss reforming Medicare, especially for the long term.

While I apologize to the Committee for being a little redundant in saying things about how bad the problem is, I think it is always important to characterize what we think we know about the near future and the long term, and the stability of the program and its financial condition, so I will start there with the numbers and comments that are familiar to you. I will not stop there, but I will spend a minute.

Spending for Medicare is expected to exceed $200 billion this year, providing benefits to 39 million elderly and disabled. Growth in Medicare spending has slowed remarkably in the last 2 years, partly because of provisions enacted in the Balanced Budget Act of 1997. Nonetheless, without reform, the program is expected to face mounting pressures in coming years, arising from rapid growth in the number of eligible people and increases in the cost of care per patient.

Mr. Chairman, I have found it useful and would invite you to think about dividing the future into three distinct periods: the next 10 years, before the baby boomers retire; the period 2010 to 2030, which is when most of the boomers do retire; and then kind of the time thereafter, 2030 to 2070.

In the first instance of the next 10 years, despite the recent slowdown of growth in spending, outlays for benefits are expected to more than double in this decade. Medicare spending will account for almost 20 percent of the budget by 2009, up from about 12 percent this year.

Mr. Chairman, after that it gets worse. Medicare's share of the budget will continue to increase rapidly for 20 years thereafter, largely because of the influx of the baby boom population. The Medicare trustees estimate that program spending will double as

a percent of our economy, double as a percent of GDP, from 2.5 to 4.9 percent in 2030. At the same time, Social Security is expected to absorb an additional 6.8 percent of GDP, bringing the total for these programs together to 12 percent of the economy, compared to 6.9 percent today. And that doesn't include other likely increases for the retirees, such as Medicare and Medicaid for long-term care.

The elderly population, Mr. Chairman, will increase by almost 3 percent a year between 2010 and 2030, rising from 39 million to 69 million people. The number of workers for each retiree will fall from 3.8 today to 2.2 by 2030, making the current system of financing virtually impossible to maintain without tax increases or substantial cost reductions. By 2070, Medicare spending is projected to grow to 5.7 percent of GDP, or a total of 13 percent with Social Security. Meanwhile, the ratio of active workers to retirees continues to fall to 2.

As the chart illustrates, the gap between spending and revenues dedicated to the program is projected to increase dramatically over time. We estimate that revenues dedicated to Medicare equals about 1.8 percent of GDP this year, substantially less than program spending.

By 2030, dedicated revenues will be about 2.2 percent of GDP, while total Medicare spending will be about 4.9 percent. By 2030, then, Mr. Chairman, general funds equal to almost 3 percent of the economy would be needed to supplement current revenues. The financial imbalance will continue to grow after 2030.

That turns out to be the good news. The bad news is that these projections assume that the growth in spending per beneficiary will gradually decline to be more in line with growth in hourly earnings, even without a significant policy change. That assumption is likely unrealistic.

Since 1980, Medicare's costs grew more than twice as fast as wages and salaries. Contrary to the assumptions made in the Trustees' Report, Medicare's costs will probably continue to grow faster than wages, reflecting continuing advances in medical technology and increases in the use of services by enrollees.

At the risk of stating the obvious, if a slow growth in Medicare is not realized, the fiscal future quickly gets bleaker. For example, if the long-term growth in hospital spending per beneficiary increased by 1 percentage point more than wages, the payroll tax increase needed to restore actuarial balance in the trust fund would more than double, from 2.9 percent of current wages to 6.5 percent.

So, in light of these sobering projections, which likely understate the extent of the problem, what can we do? There are two aspects to keep in mind in evaluating both short- and long-run reforms.

First, we need to always be mindful that the ability to pay for goods and services, including health care services, grows as the economy grows. Thus, policies that enhance economic growth will make it easier to meet the needs of the elderly population. What is most important is not necessarily the status of the trust fund, or ultimately the source of the funding for the benefits, but rather the portion of the economy that is promised to the retired population, the amount of goods and services, including health care, that must be transferred from the working population to the nonworking.

Second, the tradeoff between health care and other goods and services will be less marked if Medicare is more efficient, meeting enrollees' needs in the least costly way. Improving Medicare's efficiency may require restructuring the program more fundamentally than has been accomplished so far.

About 85 percent of Medicare enrollees remain in the program's traditional fee-for-service sector. According to our projections, that share will fall to only 70 percent by 2009. Unless reform proposals markedly reduce fee-for-service enrollment, that sector will remain dominant over the next decade, especially in less populated areas, until at least the boomers retire.

Consequently, the costs of care in the fee-for-service sector will significantly determine overall Medicare spending and efficiency for the next decade. Despite your best efforts to constrain fee-for-service costs, more fundamental reform is almost certainly necessary. A more complete discussion is included in my written statement and other CBO reports on reforms to the fee-for-service program.

Quickly, Mr. Chairman, I want to speak to a couple of long-run options that seem to be in the debate today. There may be others, but recently the debate seems to have centered around two broad approaches to restructuring the Medicare Program: shifting from pay-as-you-go financing to prefunding, and shifting from open-ended Federal payments to a defined contribution. Both of these approaches would attempt to make beneficiaries more aware of the costs and benefits of seeking additional care, and would depend on competition among health plans to ensure efficiency and maintain high standards of quality.

On the prefunding side, proposals to prefund Medicare would require people to save during their working years to finance health insurance after they retire. Ironically, that approach would put into place a self-financing mechanism that many people believe already exists with the Medicare Trust Funds. Prefunding would obviously require the working population to pay twice, once for themselves and once for their parents.

In its simplest form, a defined contribution plan would make a fixed payment, in most cases adjustable at least every year, to beneficiaries who would choose from a range of health plans, including the traditional fee-for-service program. In principle, health plans would have an incentive to compete on the basis of price and become more efficient, thereby lowering costs and reducing the future fiscal burden on workers.

The design most frequently discussed in current debates has already been evidenced here today, is the premium support model. It would retain a basic benefit package that all plans would offer. The Government's payment would ensure that at least one plan could be purchased with no more than a modest additional premium paid by beneficiaries. Plans could offer additional services and would be free to set higher premiums.

For any of these plans, Mr. Chairman, accurate risk adjustment methods are necessary if the plans are to compete on the basis of benefits, quality of service, and premium cost. Indeed, Mr. McDermott just mentioned the severe problems of adverse selection.

Eliminating all of the risks associated with high-cost enrollees would be undesirable, since financial risk promotes more efficient practices. Nonetheless, undue vulnerability to financial risk could be used by adjusting payments using risk adjusters which account for the expected greater use of services by sicker beneficiaries. Alternatively, the Federal Government could share some of the risks through such methods as blending a capitated rate with a fee-for-service payment, or providing reinsurance and stop-loss coverage for high cost cases to the providers.

The Balanced Budget Act of 1997 attempted to improve the efficiency of Medicare's fee-for-service system through payment reforms, and laid the groundwork for a more competitive system through the creation of Medicare Plus Choice. The resulting changes to Medicare's risk-based and fee-for-service sectors have slowed the growth in costs, but the BBA reforms still do not promote the best health outcomes at the lowest cost to taxpayers and beneficiaries.

The Congress could consider raising Medicare revenues by increasing the payroll tax; allocating more revenues to the program from the general fund; or increasing the costs imposed on enrollees. Options to raise revenues for the program, however, are likely to succeed only temporarily in shoring up Medicare's financing as health costs continue to escalate.

Congress could also consider reducing Medicare benefits, but that would impose greater financial burdens, obviously, on the elderly and disabled, and eventually could prove to be unacceptable.

A third approach would address the inefficient use of medical resources in Medicare. Treatment patterns vary greatly nationwide, with consequences for both health outcomes and program costs. For example, patients are more likely to be hospitalized in areas with high bed-to-population ratios than in other areas, even though they have identical medical conditions.

Medicare could be restructured to allow health plans to compete on the basis of price as well as benefits and quality. Premium support approaches, such as recent proposals from the President and that of the National Bipartisan Commission on the Future of Medicare, are potentially promising strategies to do this.

Enrollees could be given better information about their health plan choices, including a report card that could help them assess the quality of care the plans provide. Payment systems and cost-sharing requirements could be revamped to provide plans with clear financial incentives to improve both the quality of care and the efficient use of resources.

Those changes could also provide beneficiaries with better incentives to enroll in efficient, high-quality health plans, but those types of changes are possible only through fundamental reform. Making marginal changes to the current program while adding significant benefits would likely only hasten the day of reckoning.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of Dan L. Crippen, Director, Congressional Budget Office

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss reforming Medicare for the long term. Growth in Medicare spending has slowed remarkably in 1998 and 1999, partly because of provisions in the Balanced

Budget Act of 1997 (BBA). Nonetheless, without reform, the program is expected to face mounting pressures in coming years, arising from rapid growth in the number of eligible people and increases in the cost of care per patient.

PROJECTIONS OF MEDICARE COSTS UNDER CURRENT LAW

Spending for Medicare is expected to exceed $200 billion this year, providing benefits to 39 million elderly or disabled people. Despite the recent slowdown in the growth of spending, outlays for benefits are expected to more than double in the next decade.

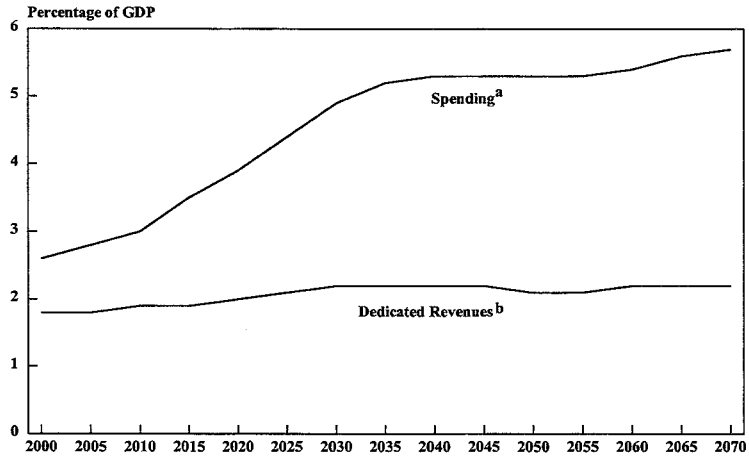
At that rate, Medicare spending will account for almost 20 percent of the federal budget by 2009, up from about 12 percent this year. Under current law, Medicare's share of the budget will continue to increase rapidly thereafter, partly because of the influx of the baby-boom population. According to the intermediate assumptions of the Social Security trustees, the elderly population will increase by about 1 percent a year between 2000 and 2010 but by almost 3 percent a year between 2010 and 2030—rising from 39 million to 69 million people. And, as in the past, Medicare's costs will probably grow faster than its enrollment, reflecting continuing advances in medical technology and increases in the use of services by enrollees.

Although such projections involve much uncertainty, Medicare has to prepare for the unprecedented demands that the baby-boom population will soon impose on it. Assuming no change in policy, the Medicare trustees estimate that program spending will grow from about 2.5 percent of gross domestic product (GDP) this year to 4.9 percent of GDP in 2030, as the last of the baby boomers enroll in the program. By 2070, spending is projected to grow to 5.7 percent of GDP. Meanwhile, the ratio of active workers to retirees will fall, making the current system of financing difficult to maintain without tax increases or substantial cost reductions.

There is a widening gap between spending for Medicare and the revenues that are specifically dedicated to the program (see Figure 1). The Congressional Budget Office (CBO) estimates that revenues dedicated to Medicare equal about 1.8 percent of GDP this year, substantially less than program spending.[1] The gap largely reflects the infusion of general funds into Supplementary Medical Insurance (SMI), which accounts for 75 percent of the cost of that program. The gap between spending and dedicated revenues is projected to increase over time, as the Hospital Insurance (HI) Trust Fund goes into deficit. By 2030, dedicated revenues will be about 2.2 percent of GDP while spending will be about 4.9 percent of GDP. The financial imbalance will continue to grow after 2030.

[1] Dedicated revenues include payroll taxes and income taxes on Social Security benefits, which are paid into the Hospital Insurance Trust Fund, plus premiums for Supplementary Medical Insurance (estimated as 25 percent of the costs of that insurance).

FIGURE 1. PROJECTED FINANCIAL STATUS OF THE HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, 2000-2070



SOURCE: Congressional Budget Office based on the 1999 annual reports of the Medicare trustees.

a. The sum of disbursements for benefit payments and administrative expenses from the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds under the intermediate assumptions of the trustees.

b. The sum of income from payroll taxes and the taxation of Social Security benefits, which is paid into the HI trust fund, plus SMI premiums (estimated as 25 percent of SMI costs) under the intermediate assumptions of the trustees.

Restoring actuarial balance to the HI trust fund for the next 75 years would require significantly increasing revenues or decreasing spending. According to the latest report of the Medicare trustees, balance would be restored in the HI trust fund if the payroll tax was immediately increased by about 50 percent—from 2.9 percent of wages to 4.36 percent—or spending was reduced by an equivalent amount. Such policies would not address the growth of SMI, which is already largely funded by general revenues.

Moreover, those projections assume that growth in spending per beneficiary will gradually decline to be more in line with growth in hourly earnings, even without a significant policy change. That assumption is probably unrealistic; if spending per beneficiary does not slow, the financial status of the HI trust fund will be considerably worse. For example, if the long-term growth in HI spending per beneficiary increased by 1 percentage point, the payroll tax increase needed to restore actuarial balance in the trust fund would more than double. Under that circumstance, the Medicare trustees estimate that the HI payroll tax would immediately increase from 2.9 percent of wages to 6.52 percent.

The nation will most likely devote more of its income to health care in the coming decades, and since the elderly will become an increasingly dominant part of the population, public acceptance of larger federal health spending may grow. Furthermore, the ability to pay for goods and services, including health care services, grows as the economy grows. Thus, policies that enhance economic growth will make it easier to meet the needs of the elderly population. But the trade-off between health care and other goods and services would be less marked if Medicare was more efficient, meeting enrollees' needs in the least costly way. Improving Medicare's efficiency may involve restructuring the program more fundamentally than has been done so far.

BBA Policies to Promote Competition Among Health Plans

In establishing the Medicare+Choice system under the Balanced Budget Act, the Congress wanted to make Medicare's risk-based sector more competitive by expanding the range of available plans—both the kinds of plans offered and the areas in which they were offered. The Congress also mandated a coordinated open-enrollment process intended to better inform beneficiaries about their options.

But the BBA left in place the administered pricing system, which sets Medicare's payments to plans. Consequently, the program has no meaningful price competition among plans for the basic benefit package. Instead, plans have incentives to increase optional benefits rather than to reduce costs, just as they did before the BBA. Changing to a premium-support or bidding system could expand competition to include price as well as benefits and quality of service, so that Medicare could capture some of the savings from plans' more efficient health care management. Many issues would have to be resolved, however, before Medicare could carry out such an approach nationwide. The competitive-bidding demonstrations mandated by the BBA, if successfully implemented, could provide some answers.

OPTIONS FOR RESTRUCTURING MEDICARE

Recent policy debate has centered around two broad approaches to restructuring the Medicare program: shifting from pay-as-you-go financing to prefunding and shifting from open-ended federal payments to a defined contribution. Both of those approaches would attempt to make beneficiaries more aware of the costs and benefits of seeking additional care and would depend on vigorous competition among health plans to ensure efficiency and maintain high standards of quality.

Prefunding

Proposals to prefund Medicare would require people to save during their working years to finance health insurance after they retire. Ironically, that approach would put into place a self-financing mechanism that many people believe already exists with the Medicare trust funds. When fully implemented, prefunding would largely eliminate the current flow of subsidies from workers to retirees. Those subsidies will become increasingly burdensome as the number of workers for each retiree falls from 3.8 today to 2.2 by 2030. Because each generation would pay for its own Medicare costs, prefunding would avoid the prospect of generations with relatively few workers having to finance the health expenditures of larger generations—a problem inherent in Medicare's current financing system.

Any switch from a pay-as-you-go system to prefunding faces a potentially long, complex, and costly transition period. Current Medicare enrollees and older workers, who have insufficient working years left to save enough to cover their health spending in retirement, will continue to depend on pay-as-you-go financing. Younger workers could face significant mandatory contributions to finance their own future insurance needs while paying additional taxes to fund the transition.

Defined Contribution

Under a defined contribution (or voucher) plan, Medicare would make a fixed payment to beneficiaries, who would choose from a range of health plans—including the traditional fee-for-service program. If their chosen plan's premium exceeded Medicare's payment, they would pay the extra amount. In principle, with beneficiaries required to pay the additional costs of more expensive plans, health plans would have an incentive to compete on the basis of price and become more efficient, thereby lowering costs and reducing the future fiscal burden on workers.

The design most frequently discussed in current debates—the premium-support model—would retain a basic benefit package that all plans would offer. The government's payment would ensure that at least one plan could be purchased with no more than a modest additional premium paid by beneficiaries. Plans could offer additional services and would be free to set higher premiums.

Accurate risk-adjustment methods are necessary if plans are to compete on the basis of benefits, quality of service, and premium cost. Plans that attracted higher percentages of high-cost enrollees would find it difficult to compete if the payments they could expect for those people did not reflect their probable costs. Instead of focusing on ways to improve efficiency, plans in those circumstances might focus on attracting healthier enrollees (a situation known as favorable selection).

Eliminating all of the risks associated with high-cost enrollees would be undesirable since financial risk promotes more efficient practices. Nonetheless, undue vulnerability to financial risk could be reduced in the following ways:

• Payment adjusters: The Health Care Financing Administration (HCFA) currently uses demographic factors for age, sex, Medicaid receipt, and institutionalization to adjust payments to plans for the expected costs of their enrollees. Beginning in 2000, HCFA will add an adjuster based on prior inpatient admissions to better account for health status. However, a payment adjustment based on prior inpatient admissions creates an obvious way for plans to increase their Medicare payments by hospitalizing enrollees unnecessarily—a problem that HCFA is well aware of.

Consequently, HCFA intends to develop a more comprehensive health status adjuster as soon as possible.

• Partial capitation: Because even the best payment adjuster can account for only a modest amount of variation in health spending at the plan level, the Medicare Payment Advisory Commission and others have suggested that some kind of partial capitation may be necessary to ensure that plans do not skimp on the services provided to their enrollees. Partial capitation could be introduced by blending a capitated rate and a fee-for-service rate, supplementing payments for unusually costly cases, providing stop-loss protection on total costs at the plan level, or carving out selected high-cost services. All of those approaches would reduce the capitation rate across the board, imposing a kind of premium on plans in return for insurance against excessive risk.

Other strategies for controlling adverse selection could reduce the demands on risk adjustment. Such strategies include coordinated open-enrollment periods, controls on the marketing of plans, and a requirement that plans offer a standardized benefit package.

REFORMING FEE-FOR-SERVICE MEDICARE

About 85 percent of Medicare enrollees remain in the program's traditional fee-for-service sector. According to current CBO projections, that share will fall to 70 percent by 2009. Thus, Medicare's fee-for-service sector should remain dominant, especially in less populated areas, at least through the next decade. Consequently, efforts at cost control must include the fee-for-service sector. Previous efforts have focused almost entirely on providers. Although some additional policy changes affecting providers could be made, changes affecting enrollees could also be considered.

Policies Affecting Providers

Paying separately for each service a patient receives encourages the provision of unnecessary services. One alternative to separate payments is a single payment, determined prospectively, for all services deemed appropriate to treat a given condition. Prospective payment encourages providers to treat the patient with the fewest services possible to adequately address the condition. Medicare has had a prospective payment system for hospital inpatient services since 1983. The BBA mandates new prospective payment systems for hospital outpatient, skilled nursing, and home health services.

Prospective payment could be expanded. One way is to bundle together payments for acute and postacute hospital services. Another way is to combine payments for physician and facility services during a hospital stay. However, developing viable prospective payment systems is difficult. Having more comprehensive bundles of services reduces providers' opportunity to shift services to sites or times not included in the prospective payment, increasing their incentive to reduce costs; but such bundling also imposes greater financial risk on providers. One way to reduce excessive risk and the resulting incentive to avoid difficult cases is to include severity adjustments in the payment system, similar to the risk adjusters applied to capitation rates for paying Medicare+Choice plans. Another option is to expand the current hospital outlier policy to compensate providers for unusually expensive cases.

An alternative approach could use competitive bidding to establish prices for individual services in the fee-for-service program. HCFA is conducting a demonstration of competitive bidding for certain categories of durable medical equipment, which Medicare currently pays for according to a fee schedule. The demonstration, in Polk County, Florida, covers hospital beds and four other categories of supplies. The agency received bids from 30 suppliers and plans to contract with 16 of them. Price reductions range from 13 percent for surgical dressings to 31 percent for enteral nutrition products. HCFA plans to begin paying suppliers under the new pricing system on October 1, although legal challenges could delay that. The animosity of suppliers toward the demonstration illustrates the general problem that HCFA faces in testing competitive bidding as an alternative to administrative price setting.

Policies Affecting Enrollees

Enrollees in Medicare's fee-for-service sector currently have to pay some of the costs of their covered services and all of the costs of outpatient prescription drugs, which are not typically covered by Medicare. In principle, cost sharing gives patients an incentive to use services more prudently. For several reasons, however, Medicare's cost-sharing requirements are not as effective in that regard as they might be. First, the requirements are too varied and complex to be well understood by patients. Second, some services (such as home health care) have no cost-sharing requirements. Instituting such requirements could help reduce inappropriate utiliza-

tion. Third, some circumstances (such as long hospital inpatient stays for severely ill patients) require high cost sharing, even though there is little possibility of reducing the use of services. Fourth, because Medicare does not limit enrollees' cost-sharing liabilities, most enrollees seek some kind of supplementary (or medigap) coverage to limit their financial risk. Such supplementary coverage often eliminates the incentives for prudent use of services that cost sharing is intended to create.

In its recent volume on maintaining budgetary discipline, CBO discussed one policy option that could better protect enrollees from catastrophic expenses and improve the effectiveness of Medicare's cost-sharing requirements. That option would change those requirements to more accurately reflect the costs of the services used and make the requirements easier for enrollees to understand. It would also cap each enrollee's annual liability for cost-sharing expenses. Medicare could implement the option for no net cost by raising cost-sharing requirements somewhat for the majority of enrollees, who use relatively few services during the year, and using those savings to finance the cost-sharing cap for the minority of patients with more serious health problems that year. One option would replace the current complicated mix of cost-sharing requirements with a single $750 deductible, a uniform coinsurance rate of 20 percent for amounts above the deductible, and a cap of $2,000 on each beneficiary's total cost-sharing expenses. That would yield $8 billion in federal savings over the next 10 years.

A complementary option, which would further increase the effect of Medicare's cost-sharing requirements, would restrict the kind of coverage that medigap plans could provide. Under one approach, those plans might be prohibited from covering Medicare's deductible amounts. Alternatively, they might be permitted to offer coverage only for a cost-sharing cap that was lower than the one provided under Medicare—such as one set at $1,000 a year when Medicare's cap was set at $2,000. Restricting medigap coverage could generate considerable savings for Medicare, which pays most of the costs of the additional services that medigap policyholders use. If, for example, medigap plans were prohibited from covering any part of Medicare's new deductible under the cost-sharing option discussed above, program savings would be about $46 billion over 10 years. Those savings could be used to improve Medicare's benefits—for example, by financing the costs of a prescription drug benefit.

THE PRESIDENT'S PROPOSAL FOR MEDICARE REFORM

The President's recent proposal to reform Medicare provides a framework for making significant changes to the program. It is intended to modernize Medicare's benefits, enable the federal government to become a more prudent purchaser of health services, and encourage price competition among health plans to slow the growth of Medicare spending in the longer term. CBO estimates that the President's Medicare reform plan would increase federal outlays by $111 billion over the 2000–2009 period (see Table 1). By comparison, the Administration estimates the 10-year cost of the proposal at $46 billion.

Table 1.—Ten-Year Estimates of the President's Medicare Proposal

[In billions of dollars]

	Administration	CBO
Benefit Payments (Increase)[a]:		
Prescription drug benefit	118.8	168.2
Changes to fee-for-service Medicare	−64.2	−48.2
Competitive defined benefit[b]	−8.9	−8.9
Subtotal	45.7	111.1
Transfers from the General Fund	327.7	327.7
Total	373.4	438.8

Sources: Congressional Budget Office (based on the July 1999 baseline) and Office of Management and Budget.
[a]Includes effect on Medicaid.
[b]Administration's estimate.

The President proposes a new prescription drug benefit that would provide first-dollar coverage, with an annual limit of $2,500 in 2008, when the benefit was fully phased in. Although most Medicare enrollees would receive some benefit, the proposal would not substantially protect those in poor health who incurred very large out-of-pocket expenses for prescription drugs.

Under the President's proposal, the federal share of the prescription drug benefit would be paid through transfers from the Treasury's general fund. Those transfers are simply promises to pay future benefits with future tax dollars. How burdensome that commitment might become depends on both the growth of future spending for prescription drugs and the growth of the economy over the coming decades.

The Balanced Budget Act includes provisions that limit updates, and the President proposes to extend some of them beyond their 2002 expiration date. The President would also provide a small amount of additional funds to reduce the impact of the act's payment reductions through as-yet-unspecified legislation. On balance, payments to providers would be lower than baseline levels, but only after 2002.

Reducing payment rates for fee-for-service providers would yield Medicare savings without contributing to the program's efficiency. But improving the efficiency of the fee-for-service sector is key to achieving short-term cost savings and longer-term reform. Successful adoption of the contracting and payment methods that private health plans use to manage their costs could establish the basis for a competitive fee-for-service sector. But recent efforts to test such methods have not found much acceptance among providers, and the President's proposal treads lightly on that issue.

The President's provisions for rationalizing cost-sharing requirements would modestly increase some of those requirements and lower others, without reducing their complexity. A more thorough reform might subject all Medicare-covered services to a single deductible and uniform coinsurance rates, at the same time placing an annual limit on the amount that enrollees paid in cost sharing for all covered services (including drugs if that benefit was added to the program).

The President's proposal for a competitive defined benefit would provide new opportunities for Medicare's managed care plans to compete on the basis of price as well as the generosity of benefits and the quality of service. Although the proposal would introduce elements of competition among health plans that could help slow the growth of Medicare spending in the longer term, it would fall short of a fully competitive program. By establishing the fee-for-service sector as the benchmark for defining Medicare benefits and setting premiums for health plans, it would blunt the incentives for efficiency.

CONCLUSION

The Balanced Budget Act of 1997 attempted to improve the efficiency of Medicare's fee-for-service system through payment reforms and laid the groundwork for a more competitive system through the creation of Medicare+Choice. The resulting changes to Medicare's risk-based and fee-for-service sectors have slowed the growth in costs. But the BBA reforms still do not promote the best health outcomes at the lowest cost to taxpayers and beneficiaries.

The Congress could consider raising Medicare revenues by increasing the payroll tax, allocating more revenues to the program from the general fund, or increasing the costs imposed on enrollees. Options to raise revenues for the program, however, are likely to succeed only temporarily in shoring up Medicare's financing as health care costs continue to escalate. The Congress could also consider reducing Medicare benefits, but that would impose greater financial burdens on the elderly and disabled that could eventually prove unacceptable.

A third approach would address the inefficient use of medical resources in Medicare. Treatment patterns vary greatly nationwide, with consequences for both health outcomes and program costs. For example, patients are more likely to be hospitalized in areas with high bed-to-population ratios than in other areas, even though they have identical medical conditions. Patients in fee-for-service settings rely more on specialist and hospital care than patients in managed care. In addition, managed care settings emphasize disease prevention and primary care more than fee-for-service settings do.

Medicare could be restructured to allow health plans to compete on the basis of price as well as benefits and quality. Premium-support approaches, such as recent proposals from the President and the National Bipartisan Commission on the Future of Medicare, are potentially promising strategies. Enrollees could be given better information about their health plan choices, including a report card that could help them assess the quality of care that plans provide. Payment systems and cost-sharing requirements could be revamped to provide plans with clear financial incentives to improve both the quality of care and the efficient use of resources. Those changes could also provide beneficiaries with better incentives to enroll in efficient, high-quality health plans. But those types of changes are possible only through fundamental reform. Making marginal changes to the current program while adding significant benefits would only hasten the day of reckoning.

Chairman THOMAS. Thank you, Mr. Crippen.

In terms of your chart, and I know it is on page 3 of your testimony, so people appreciate what "dedicated revenues" mean, that is basically the HI Trust Fund, any Social Security transfers, and it is the part B premium——

Mr. CRIPPEN. Yes, sir.

Chairman THOMAS [continuing]. That is paid, as well. So, obviously, take 2070, since that is a vertical line that we can measure. The white part on the lower end would be the dedicated revenues. The red up to spending would be the general fund?

Mr. CRIPPEN. Yes.

Chairman THOMAS. And of course some of the concern that folks have, recalling membership on the Commission, Senator Kerrey, I think, was one of the more adamant ones about the problem of relying more and more on general fund means you have fewer dollars available for other programs.

My guess is that the 50–50 mark is somewhere around 2025, and that is, beyond that there would be more coming out of general fund than the dedicated revenues.

Mr. CRIPPEN. It is probably toward the end of the baby boom generation.

Chairman THOMAS. Roughly.

Mr. CRIPPEN. But you are right, 2030, 2025.

Chairman THOMAS. And it starts flattening out after that baby boomer climb, because once we digest the baby boomers, if we can get through to about 2050, at least current demographic trends indicate that that will be more of a constant line that we are dealing with.

Mr. CRIPPEN. Yes.

Chairman THOMAS. Do you have any idea, from what we project budgeting to be, what that red zone would be from the general fund?

Mr. CRIPPEN. In billions, I don't. Everything we prepared for today——

Chairman THOMAS. Percentagewise?

Mr. CRIPPEN [continuing]. Was percent of GDP, in which it will be almost 7 percent of GDP by 2030.

Chairman THOMAS. And it is currently now, what did you say?

Mr. CRIPPEN. 2.9, I believe.

Chairman THOMAS. 2.9, and you extrapolate that out, the concern of Senator Kerrey was that the portion of the general fund being dedicated to this one particular program would begin to crowd out options available, not unlike the concern that people were having about the interest payments on the national debt——

Mr. CRIPPEN. Yes.

Chairman THOMAS [continuing]. Going for yesterday's payments and not current uses.

Mr. CRIPPEN. For comparison purposes, today the Federal Government employs about 20 percent of GDP for all of its various programs. By 2030, Social Security and Medicare alone, we project, would consume 12 percent, so well over half of what the Federal

Government currently enjoys as part of the economy would be in these two programs alone.

Chairman THOMAS. One additional question, because the President has offered, as you indicated in your testimony and the gentleman from Washington indicated, at least a partial proposal in terms of competition, but he also included the concept of prescription drugs, and the Bipartisan Commission proposed an integrated approach to prescription drugs.

Doesn't the President's plan, if in fact it were enacted, require greater contributions on the part of beneficiaries for the overall program as envisioned? Or does he do it for the same beneficiary contribution?

Mr. CRIPPEN. No, it would envision that there would be—50 percent of the premiums would be paid by beneficiaries.

Chairman THOMAS. So it would be an increase on the beneficiaries. So the President's plan says the beneficiaries need to pay more, for sure to get more, but they have to pay more. The Commission plan said beneficiaries would have to pay more to get more.

I think the basic concept is that if you are going to give more, you have got to talk about paying more, and I was pleased to see that the President was realistic in that regard and didn't try to talk about the fact that you can get something from nothing, either from changing from traditional payment of Medicare operating costs and shifting to drugs. In fact, I think they talked about that a little bit, but backed away from it relatively quickly.

No one, I think, is talking about putting less money into Medicare. We are talking about bending the growth curves in ways that we can live with them, and hopefully we can generate some additional new ways of talking about providing responsive and appropriate care for seniors at reasonable cost. And I want to thank you very much for your testimony.

The gentleman from California?

Mr. STARK. Thank you, Mr. Chairman. I am inclined to agree with you. Somebody is going to have to pay more, but I guess the debate may come down to whom, what cat we bell.

Mr. Crippen, off the top of your hat, can you pick a payroll tax figure that would make Medicare solvent for all time, whatever "all time" is? I think I have heard bandied around that if we kicked it up 1 percent, a half percent for employers and a half percent for employees——

Mr. CRIPPEN. That may be right, Mr. Stark. I have got the——

Mr. STARK. Do you know, is there a figure that you are aware of?

Mr. CRIPPEN. There is a figure. The trustees have it in their report, I believe. I think it is more like 2 percent of payroll under——

Mr. STARK. A point on each. So there is an alternative, at an extreme, I suppose, to say OK, instead of paying what we pay now, we could increase that a percent on wage earners and on employers, and that would take care of it without making any other changes, basically. That is not to say we wouldn't, but——

Mr. CRIPPEN. It would, under the current trustees' assumptions. As I cautioned, those assumptions may be optimistic, but——

Mr. STARK. Yes, but that is a long time out, too, that we are talking about.

Chairman THOMAS. Would the gentleman yield for clarification purposes?

Mr. STARK. Sure.

Chairman THOMAS. A 1-percent increase is not a 1-percent increase.

Mr. STARK. No, it is an additional percentage.

Chairman THOMAS. And what would that be in terms of a percentage above the current rate?

Mr. STARK. What do we pay now?

Chairman THOMAS. When you say 1 percent, it sounds like that is a pretty easy solution. So it would be total 2 percent, and what is the current HI tax?

Mr. CRIPPEN. 2.9 percent.

Mr. STARK. 2.9.

Chairman THOMAS. So it would be, what, a 40 percent, 40 to 50-percent increase in the current HI tax, in other words?

Mr. CRIPPEN. It looks like, Mr. Stark, the answer to your question is that the trustees estimate it would take to go from 2.9 percent to 4.36 percent, so it is not—you know, two points altogether, one on employees, one on——

Chairman THOMAS. And what percentage is that of an increase of the amount they pay now?

Mr. CRIPPEN. It is almost 50 percent.

Mr. STARK. So it is a 50-percent increase.

Chairman THOMAS. OK. Thanks. Fifty-percent increase.

Mr. STARK. And the question, you know, would come down to if it is a 50-percent increase on all of us, on a very modest and small tax, as opposed to maybe several thousand dollars, $3, $4, $5, $6,000 on seniors, particularly those who, if they have no pharmaceutical benefits, that is taking 10 percent of their—10, 20, 30 percent, it might kick the percentage they now pay.

What do seniors on average now pay of their income for medical costs? There is a number. Does that one ring a bell in your memory?

Mr. CRIPPEN. I don't have here an exact number. It might be $2,500 out of pocket?

Mr. STARK. $2,500 out of pocket, and their median is about $25 grand, maybe less, so 10 percent. So either way you want to slice it, if you kick up a couple thousand dollars for those folks in increased pharmaceutical costs, that could be a 100-percent increase on people who perhaps can less well afford it.

But I just kind of would like to focus everybody's attention that the choices might very well be, certainly the 1 percent on employers, who are making all time high profits, shouldn't be of any problem in today's booming economy. And for the rest of us, we all just got a raise, thanks to the generosity of our Republican leadership. We could afford it. And that might be less painful than it would be, certainly it would be less painful for me than it would be for my mother with her modest income.

I just wanted to get those numbers out and say there are those alternatives. I guess my one other question—well, thank you. I yield back.

Chairman THOMAS. The gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you, Dr. Crippen. I want you to enlarge on the part of your testimony where you discuss the issue of competition, and particularly how you move from or what the relationship between an administered price system and a competitive system, and what you see as how the administered price system—at least your testimony implies that it inhibits the base from which the competition in the competitive system would start. I mean, that is the way I hear it. Could you enlarge on that?

Mr. CRIPPEN. Let me try.

Mrs. JOHNSON. And what would be the way out?

Mr. CRIPPEN. Let me make one point and then one example, and go from there, and see if this gets to your question.

The example is, and actually Mr. McDermott and I had an exchange about this a couple of months ago, there are currently about 50 percent too many hospital rooms across the country. We don't know where exactly, but there is excess capacity.

It is not to say you could ever cut 50 percent of costs by eliminating hospitals, but the point is, there is some excess capacity, so there is room for efficiencies of some sort, whether it is deploying those rooms for skilled nursing facilities, shutting them down, all kinds of other options. So the point is, the system as currently constructed has room to do better.

How we get competition in could be slow and incremental. It could be by giving the beneficiaries more choices and letting them instill the competition by choosing. Let me give you one quick example.

One thing that we have talked about a little is, for Medicare recipients, for example, there are some very costly procedures, although not common, but costly, such as liver transplants. One could offer up a national competition on liver transplanting, or on both price and outcome, because we do have some outcomes data on whole organ transplants that might make sense: the length of hospital stay, rehospitalization, mortality, other things.

In such a competition, the last I checked, at least, the Mayo Clinic would likely win on both points. That is, it would provide a less costly liver transplant with at least as good if not better outcome than other places. One could use that result to come up with an average price that Medicare is willing to pay.

You could allow beneficiaries to go wherever they wanted, but the price that Medicare would pay would be based on this competition, which would give you the best price but also potentially the best outcome, give information to beneficiaries as to who does a better job with these kinds of procedures. And by pulling these very costly measures out of a capitated payment or even the current fee-for-service system, you start to put more competition into the system, and you make the resulting pool that is left a little less risky, which makes it easier to have a risk-sharing arrangement or indeed a fully capitated arrangement.

Mrs. JOHNSON. Now, the private sector, for instance the Federal Employee Health Benefit Plans, don't exclude liver transplants as a possible medical treatment. Why couldn't we set the premiums for a Medicare managed care plan in a sense the same way we set premiums for the Federal Employee Health Benefit Plans, adjusted

of course for age, and let that premium deal with this issue of liver transplants and what we are going to pay?

The problem with the model you describe, of determining what should be paid for a liver transplant, is that it doesn't take into account so many other factors like transportation and the distance from family and things like that, and all the other things that go with having one or two centers that perform a certain service for Medicare recipients. And then you get into frailty issues and a lot of things.

So why can't you just move to this other system which we use in every other sector of the health care industry?

Mr. CRIPPEN. That is certainly what the chairman's Commission recommended, was I mean very much modeled after the FEHB Plan, and you could do something like that. Frankly, the pricing in FEHB is, because of my ignorance, still a bit of a mystery for me. There are a lot of moving pieces in it. There is not a fixed benefit plan, as you know, and people can move easily between plans.

Mrs. JOHNSON. So one of the things you would need to do is to clarify what the fixed benefit plan is.

Mr. CRIPPEN. You would have to go from a mandated price to a mandated benefit, and then in the system adjust prices around for that. But again, our view essentially as an institution at CBO is, anywhere you can instill some competition to take advantage of what appears to be the potential efficiencies, whether it is hospital rooms or differences in procedures, currently will better utilize current resources. So in addition to adding resources, you can better utilize what you are doing now.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. The gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you very much, Mr. Chairman.

Dr. Crippen, I have a quick question. You indicated that currently about 85 percent of the Medicare beneficiaries avail themselves of fee-for-service, and projected over the coming years that will probably drop to about 70, but you indicated that wasn't a heck of a lot of a drop.

Is it your view that if we move to a premium support plan, that that fee-for-service percentage would drop much more rapidly?

Mr. CRIPPEN. I don't really have a view on that. We have not had and do not have in front of us a specific legislative proposal that we have had to make those decisions about.

Mr. KLECZKA. Well, based on the Commission proposal, would you view that as——

Mr. CRIPPEN. The actuaries, when they first looked at it, not in this last round apparently for Mr. Stark, but when they first looked at it, did think there would be some diminution, more people moving out of fee-for-service into other health plans. We don't, I don't think, have an opinion on that.

Mr. KLECZKA. And the theory was that the program would then save X amount of dollars because of this shift?

Mr. CRIPPEN. Not so much because of the shift. It is because we think there may be efficiencies out there, whether it is in fee-for-service, and there are some ways to get at those, that inefficiency, as well. But because of the ability of recipients to choose, and in

the exercise of that choice instilling some competition between plans on, if not price, then quality or benefits, that if that—it is the choice, it is the competition that produces it.

Mr. KLECZKA. But it seems to me that if the goal is to try to decrease the number of fee-for-service beneficiaries, we can do that by legislation without a wholesale shift to a program like premium support.

Mr. CRIPPEN. I think it is the ability of the recipients to choose. Not only is it desirable in some metaphysical way——

Mr. KLECZKA. Well, that is something we say every 2 years when we are back on the streets of our districts, running for reelection.

Mr. CRIPPEN. Right.

Mr. KLECZKA. "I'm not going to take away your right to choose."

Mr. CRIPPEN. Yes.

Mr. KLECZKA. Then when we come to Washington, and in my case 800 miles away, now we start doing certain little things to reduce the participation in fee-for-service without saying the words "right to choose."

Mr. CRIPPEN. But it is in that exercise of choice, not in the kind of metaphysical or political sense, it is in the exercise of that choice we expect consumers would help instill more efficiency in the delivery systems.

Mr. KLECZKA. OK. Thank you.

Chairman THOMAS. I thank the gentleman.

The gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Yes, thank you, Mr. Chairman.

Mr. Crippen, I thought I heard you say that the payroll tax fix for Medicare would require the Federal tax to go up from 2.9 percent to 4.63 percent. Is that right.

Mr. CRIPPEN. Thirty-six. Four point thirty-six.

Mr. MCCRERY. Four point thirty-six. OK. Well, even at that, I think we are looking at closer to a 60-percent increase than we are a 50-percent increase in the payroll tax, so I just wanted to get that straight.

Also, does that assume that the payroll tax increase would go into effect immediately?

Mr. CRIPPEN. Yes.

Mr. MCCRERY. At January 2000 or January 1999 or——

Mr. CRIPPEN. I would have to look at the Trustees' Report, Mr. McCrery. We get that number directly from the trustees, and I think it is a calendar year, so it would be—but it is assumed that you have to raise it now, forever, that amount, in order to close the gap.

Mr. MCCRERY. And, again, I would assume that to close that gap, the trustees would assume that the excess in Federal tax revenues over expenditures in the short term would be invested and interest gained on that investment. That is part of the fix.

Mr. CRIPPEN. Presumably, yes.

Mr. MCCRERY. And those interest payments are going to have to be paid from general revenues at some point.

Mr. CRIPPEN. Yes.

Mr. MCCRERY. So if we were to wait a year or two or five, the 4.36 percent would become something higher than that?

Mr. CRIPPEN. Yes. And I should say again, too, that the percentages we are talking about are for the Hospital Insurance Trust Fund. It doesn't include increases in premiums in part B, which have of course general revenues going into as well.

Mr. MCCRERY. Right.

Mr. CRIPPEN. So there would be more general revenue in addition to this payroll tax increase.

Mr. MCCRERY. And since I don't hear anybody yet proposing that we increase the payroll tax today, or January 2000, we are really talking about a higher increase than the 4.36 percent, aren't we?

Mr. CRIPPEN. Most likely.

Mr. MCCRERY. I don't know how much you have looked at health care and Medicare, but have you looked at it enough to draw a conclusion as to the inevitability of these rises in cost to the Medicare Program? Is that inevitable, no matter what we do in terms of structural reforms, or do you think there are flaws in the way the program is designed now which lead to some of the increases in costs?

Mr. CRIPPEN. I guess, on the whole, the short form of the answer is more the latter. That is to say, we are hopeful that some reforms could instill some competition that would take advantage of potential efficiencies in delivery, so that the current system may spend more money than it needs to. So reforms, in other words, could help bring down these cost increases.

It is, however, immutable that we are going to have a lot more people before very long taking advantage of this program. That is not something you can change. It will go from 39 million recipients to 69 million recipients in from 2010 to 2030, and you and I aren't going to change that.

Mr. MCCRERY. Can you give us some of the elements of the structural reform that would lead to increased competition and therefore lower increases in costs?

Mr. CRIPPEN. Well, some of the things we have already talked about, I think. In general, what CBO believes is that anywhere you can instill more competition and more choice by beneficiaries, they will do what is in their self-interest, which is to pick either cheaper or better plans. And in so doing, you will drive some of the inefficiencies out of the current system.

So that is the overarching umbrella. Now, below that, I mean, it is easy for me to say, because it is very hard for anyone to write a bill and implement it. Your colleagues are grappling with that now.

Mr. MCCRERY. If that is the case, then what is the explanation for Mr. Stark's statement, which I think is accurate—or maybe it is Mr. McDermott's statement that was accurate—that very little of the savings associated with the Commission's plan comes from the structural changes? First of all, is that accurate? And, second, why is that, if what you have just said is true?

Mr. CRIPPEN. I can't answer the first question. We have not priced or otherwise scored a plan like the Commission's.

But, again, to the extent we believe there are savings possible in these reforms, it comes mostly from giving people more choice and competition, therefore more efficient delivery. It does not come so much from any inherent cuts in benefits.

Mr. MCCRERY. OK. Thank you.

Chairman THOMAS. The gentleman from Georgia wish to inquire? Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. Director, during the August break I had an opportunity to meet and visit with several hospital administrators, and based on those visits in the fifth district of Georgia and from people throughout the State of Georgia, I wrote a letter, I believe to the Ranking Member and to the Chairman of the Subcommittee, regarding my strong concern about the financial impact of the Balanced Budget Act on hospital and skilled nursing facilities in my district and the State of Georgia.

I notice in the President's Medicare reform proposal he set aside $7.5 billion for BBA fixes. To my knowledge, the Breaux-Thomas proposal doesn't set aside any money for such fixes. Is there any plan by Chairman Thomas, to your knowledge, to fix the financial impact of the BBA, and where would the money come from?

Mr. CRIPPEN. I will let the Chairman address the question of him. We do have and I can report that we are working with the Congress on just scoring and helping them analyze a number of additions back to some of the BBA reductions, but they are all over the board.

I mean, whether it is 7.5 that the President over 10 years proposed, or more or less, it depends on what day and which proposal. But there certainly is active consideration, I am assuming by Mr. Thomas as well as his colleagues in the Senate, on adding back to some of these areas before the end of this session.

Mr. LEWIS. In your position——

Chairman THOMAS. Would the gentleman yield?

Mr. LEWIS. Yes, briefly.

Chairman THOMAS. The discussions have been over where it might be appropriate. Where numbers were used as plug numbers because there was to be generated new scoring mechanisms, prospective payment systems, and where they have not been able to be generated, the argument being the Y2K problem, some of those numbers that were supposed to be there for 6 to 9 months are now going to be there for 2 or 3 years, and that is just not a reasonable way to go.

The costs can be adjusted in part by administrative decisions, if it is possible statutorily, stretching out time lines, or there may have to be some legislatively enacted provisions. And what we are doing is discussing actively with the Administration what seems to be the administrative changes, No. 1, that could be made and, No. 2, that would be made by the Administration.

So it is very difficult to put a dollar value on what we would have to carry from a legislative or a statutory point of view until we work out what portion of the load they can and would be able to carry, versus what we think needs to be done and would have to do legislatively. And we are in those discussions right now.

I thank the gentleman for yielding.

Mr. LEWIS. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Just briefly, Mr. Chairman.

Dr. Crippen, as you know, Minnesota delivers high quality health care very cost efficiently and effectively, and we are penalized under the current program for being efficient. Could you comment on, in your judgment, how a premium support model like the Breaux-Thomas proposal would address inequities facing Minnesota's seniors? Wouldn't it at least bring a more level playing field, not only for Minnesota's seniors but across the Nation for all beneficiaries?

Mr. CRIPPEN. It could, Mr. Ramstad. Again, the devil is in the details and how one establishes the floor and the allocation formulas. It certainly has every prospect for doing that, from what we know at the moment, but one cannot say definitively that the Minnesota recipients would get more or less until we had looked at the details. But it would appear that it is possible that using the national averages for the basic benefit package in the kinds of proposal that are being discussed would raise the rates.

Mr. RAMSTAD. And I certainly will follow up with the other witnesses and the other panels with that major concern that we have. Too many times do I hear that seniors can receive two and a half Medicare surgeries at the Mayo Clinic, which you mentioned earlier in your testimony, for every one in Miami, Florida or New York City or a lot of other places.

I want to just shift gears and ask also, in your testimony you refer to premium support as a defined contribution. Isn't there, however, a difference between premium support and a defined contribution model, where in premium support the government contribution varies with the average cost, not some arbitrary fixed amount that may not actually cover seniors' health care needs?

Mr. CRIPPEN. No, you are absolutely right. I didn't mean to imply, and I apologize if I did in the testimony, that it would be one number for everyone. Clearly there are abilities to adjust. What I was trying to connote was, as a broad category it would be a move away from what is currently thought of as a defined benefit to one in which it was more like a defined contribution.

But, again, one of the characteristics at least of the Commission's recommendation was that there would be a basic benefit package, and then on top of that you would add essentially a defined contribution. So it would be a hybrid of both. I didn't mean to make it sound that there is only one or the other choice. You can obviously mix them.

Mr. RAMSTAD. I appreciate that clarification, and yield back, Mr. Chairman. Thank you, Dr. Crippen.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I have a feeling I am before the Kansas school board here, where we are talking about competition and there is the belief that it works. I have a chart here which is compiled from looking at CBO figures and our own figures.

In 1998 Medicare went up 1.5 percent and Federal Employees Health Benefit Plan went up 8.5 percent. Now, one is an administered plan, that is Medicare, and the other has competition in it. Everybody says managed competition is just like the FEHBP. And

so we have a 7-percent increase over what Medicare was able to do during that period.

Then we go to 1999, where the estimates from CBO were minus, actually a reduction of 1.2 percent, and the FEHBP went up 8.9 percent, so we have got more than a 10-percent increase over what Medicare did in 1999. And in 2000 we have the CBO projections of 7.2 percent, and in yesterday's paper or Monday's paper, I guess, Sunday's paper, we had an article that the Federal Employees Health Benefit Plan is going to go up 9 percent, so we are even 2 percent this year.

Now, I hear you say, and I listened very carefully, you said, "We believe that competition will lower costs." But the Federal Employees Health Benefit Plan, which is put out there as the model that we should be creating for senior citizens, with a totally different population—not young people, not working people, but we're talking about old people—that this plan that can't do it for young people is suddenly going to work for old people. Where do you get that belief?

Mr. CRIPPEN. Let me answer in a couple of ways. First, as I understand, at least part of the debate on creationism versus evolution depends on where you begin. If you think the Earth is 3 million years old, you may be an evolutionist. If it is 6,000 years old, you may be a creationist.

Mr. MCDERMOTT. I was thinking 4004 B.C. was where we started. Maybe it is——

Mr. CRIPPEN. And making that a little more relevant to your question.

Chairman THOMAS. Maybe we should ask Strom Thurmond.

Mr. CRIPPEN. That is true. He would know. He would know the difference.

It depends on when you begin, and even with the FEHB comparisons. In fact, the folks that work with me anticipated that this might come up and have given me a list of increases in FEHB compared to both private and Medicare, and it depends largely on what year you pick as to whether or not, and therefore probably doesn't show you much. For example, in 1994 Medicare spending went up 11.4 percent, FEHB premiums went up 1.6 percent. So it depends a bit on when you start and stop.

There is also a lot, as I suggested to Mrs. Johnson, a lot of moving parts in FEHB in terms of what the plans can provide, do provide, and also that the announced increases, such as you heard earlier this week, don't necessarily end up being the actual increases because people do exercise choice and go to lower cost plans. So the weighted average, although it is anticipated would be whatever the announcement was this week, 9 percent, will probably end up being more like 6 or 7.

That is not to take away your point. All I am saying is, there are a lot of moving parts and it depends. That comparison between FEHB and Medicare, varies from year to year. It looks like FEHB is just picking up in the end of an underwriting cycle. They have been lower than Medicare for a while. Now they are going to be higher. That, as you well know, in private or public insurance, happens.

Mr. MCDERMOTT. The fact is, the Urban Institute put out a chart which I assume maybe Dr. Moon or someone will speak to, which shows that the private health insurance industry has always been higher than the Medicare spending over the last—well, beginning as far back as 1970.

Chairman THOMAS. Would the gentleman yield?

Mr. MCDERMOTT. I mean, this is 1970 to 1997, and the cumulative growth has been considerably less than private insurance, where we have had all this competition and we have had all this putting people in HMOs and everything else, and the fact is that we now have, today's article out of the newspaper is that the HMOs are taking back all their drug coverage. That is the most recent thing, and we saw all over this country HMOs pulling out of rural areas. So the idea that competition is the way to work I think comes off a very shaky base. And I think, Mr. Chairman, before we go leaping to see that as our solution, we have to be very careful to look at the numbers and see that it really does work. I don't think there is any evidence that you can show, that really shows that they win in the end.

Chairman THOMAS. I thank the gentleman. My query was, as Dr. Crippen indicated, it depends on what years you pick. My question would have been, why did she start it in 1970, since Medicare started in 1965? My assumption is that starting the curve in 1970 gave a different look than going back to 1965. Again, it depends upon when and how you want an outcome, as to what you use.

The gentlewoman from Florida wish to inquire?

Mrs. THURMAN. Thank you, Mr. Chairman.

Dr. Crippen, let me go to maybe what Mr. Ramstad was talking about as well, because some of us feel a little neglected on this HMO stuff, and particularly as we then start talking about going into a premium support theory or the theory of this premium support.

In your testimony you say that they would retain a basic benefit package that all plans would offer. Now, is that based on the same costs that are being given to these HMOs today, where there would be the built-in difference from regions in what is being costed out?

Mr. CRIPPEN. Again, presumably the—we don't have at CBO a bill to which we could answer that very specifically. Presumably, any system of payment for a basic benefit package would include regional or State variations in costs. The old AAPCC, as you may know, on which were kind of based managed care payments now, was down to a county level. There were some problems with that.

But presumably there will be some factoring in of differences in regional variations in costs. The policy, one of the policy questions is, do you also factor in regional variations in practice patterns? As you know, it varies across the country, depending upon where you are and what kind of treatment you get. Some of those treatments are more expensive than others. And do you want to encourage that?

I mean, those are the kinds of complex mixes. But I would imagine virtually any plan would account for basic cost differences among regions.

Mrs. THURMAN. However, I mean, it has just been reported that in the Medicare Plus Choice we have overextended maybe about

$1.3 billion in some of these cases. I think GAO came out with that.

Mr. CRIPPEN. That I am not aware of, Mrs. Thurman, but the Comptroller General is right behind me, so you can——

Mrs. THURMAN. Fine. And I guess my concern is if we built back in the same problems that we have had in the past, and the issue really to me is one of parity. I mean, I am spending my money into my payroll to get my Medicare when I reach that magical age, and if I live in one part of the country they may get $800, where this other part, or even within a State, only gets $400.

Well, what really becomes something that I think all of us should be very concerned about is, that is that same person's money, and one is getting $800, one is getting $400. But worse yet, what ends up happening is that the one who is getting the $800, because we have built this in, gets an extra benefit. They might get the prescription drug or they might get eyeglasses or they might get something else. The person or the beneficiary over here who gets $400 in this region is getting no extra benefit, and any extra benefit that they get, they are having to pay a premium on top of this, where this other group is not.

So I am trying to figure out, why would I go into any of this and not stay in some sort of a fee-for-service, where at least I am treated equally, or at least to get rid of these choice issues or straighten out this formula somehow? I mean, how does a premium support help that situation?

Mr. CRIPPEN. In theory, those who are joining a managed care plan now are giving up something, whether it is choice of doctors or something else, so that they are willing to give up part of their choice in order to have better benefits. I mean, that is part of the notion of care. Clearly, the $400 versus $800, whether it is Iowa versus New York, originally was based on differences in costs for a roughly equal benefit package. Again, it incorporates some differences in practice patterns.

To the extent that is the case, I mean, the person in Iowa presumably paid in less as well. Payroll taxes would probably be lower, wages are lower, all that stuff. How it all comes out is a complex question of what you paid in versus what you expect to get out, how sick you are, and all of those things that we try to factor in. But clearly there are——

Mrs. THURMAN. But you still end up in the same situation if you did then a cost at the end. So say you were that person or this area that was getting $800, and in the testimony it talks about, well, you could add a premium onto there so you could get additional. But if you were getting $800, the premium for that additional benefit still may be less than what somebody who over here is getting $400, so you are back into the same situation that we are today.

Mr. CRIPPEN. It is possible, sure. I mean, again, the devil is in the details of how the distribution is going to work. I think that at least, at a minimum, cost differences would be accounted for.

Beyond that, it does—it can be—I worked for a fellow at Brookings at one time who said that people have a propensity to complexity things. We can certainly make this formula very complex, in a way that could have unforeseen outcomes. But, again, if it at

least reflects the differences in costs for some basic benefit package, as it in theory does——

Mrs. THURMAN. However we are not sure that that is what has happened. We think that these have been just set in the BBA and they have not changed, and we have not looked at any of those circumstances.

Mr. CRIPPEN. No. They have been frozen, yes.

Mrs. THURMAN. OK. Thank you.

Chairman THOMAS. I will tell the gentlewoman that that was one of the concerns about arbitrary formula rather than reflecting real world prices, but that is not unlike the problem where people collect pensions, having worked in one State, moved to another one because the costs are so much lower, their dollars go further, and the attempt by the first State to try to collect taxes because, after all, they made their money here and they have left. Florida should have some familiarity with——

Mrs. THURMAN. It is called a source tax.

Chairman THOMAS. Yes, the idea being that there are different prices in different regions, and one's dollar can go further in one region versus another. So trying to create some equity on a pure dollar amount would, in fact, result in significantly different or more housing, groceries, medical care, or any other number of items, based upon the prevailing wage rate and other structures in the community that they are in.

The best solution, for me, is to simply take whatever the real costs are in that location and have folks compete against each other, using those real dollar costs, to produce a product. I mean, that is kind of what we have been talking about.

Mrs. THURMAN. But those also can be inflated from one region to another by whoever is making those determinations, and I think that is all——

Chairman THOMAS. The determination should be one plan against another, and the key there is to have enough plans so that it is a competitive controlling factor. But we will obviously be talking about this.

Mrs. THURMAN. We will talk, yes.

Chairman THOMAS. I thank the gentlewoman very much.

If there are no additional questions, I want to thank the director very much for your presentation.

And I want to announce to the audience that although we had planned a separate presentation by Mr. Walker, Comptroller General of the U.S. General Accounting Office, because of the time constraints of several of our witnesses who have gone out of their way to come here again this week, if the panelists would allow us, we could perhaps combine Dr. Walker with the other panel and put the presentations and the questions together and try to do it all at once.

If I hear no strenuous objection to that, I would ask Mr. Walker to come forward, and then the panel that was to follow after that: Gail Wilensky, Dr. Wilensky, as you know, Project HOPE, Bethesda, Maryland, but also chairman of MedPAC, a structure we rely heavily on for information and policy decisions; Dr. Bryan Dowd, who is a professor of the Division of Health Services, Research and Policy at the University of Minnesota in Minneapolis;

and the aforementioned Marilyn Moon. Dr. Moon is a senior fellow at Urban Institute.

I want to thank all of you for your cooperation. I would then say that Mr. Walker is the seventh Comptroller General of the United States. It is a pleasure to have you with us. Your written testimony will be made a part of the record, and you can address us in any way you see fit in the time that you have available.

STATEMENT OF HON. DAVID M. WALKER, COMPTROLLER GENERAL, U.S. GENERAL ACCOUNTING OFFICE

Mr. WALKER. Thank you, Mr. Chairman, Members of the Subcommittee. I appreciate the opportunity to be here today to discuss efforts to reform the administration, structure and financing of Medicare, steps that are essential to maintain the programs long-term sustainability and to its modernization.

The long-term cost pressures facing this program are significant. In fact, Medicare and other health care expenditures may represent the single largest threat to our fiscal future. Fundamental program reforms are vital to reducing the program's growth, which threatens to absorb an ever-increasing share of the Nation's budgetary and economic resources.

Currently, Medicare is not a sustainable program, based on current financing. As noted in Exhibit 1, which is on the left, Medicare's HI component is on a cash basis in the red, and it has been in the red since 1992. To finance this deficit, Medicare has been drawing on its special issue Treasury securities acquired during the years when the program generated an annual cash surplus.

Consequently, Medicare is already a net claimant on the Treasury, a threshold that Social Security is not expected to reach until 2014. In essence, for Medicare to redeem its securities, the Government must either raise taxes, cut spending on other programs, or reduce the projected surplus. Outlays for Medicare services covered by SMI are already funded largely through general revenues, and as you know, HI is not.

Without meaningful reform, the long-term financial outlook for Medicare is bleak. Today, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from 12 percent of all Federal revenues in 1999 to more than a quarter of Federal revenues by mid-next century.

As noted in Exhibit 2, over the same timeframe, on the right, Medicare's expenditures are expected to more than double as a share of our economy, rising from 2.5 to 5.3 percent. When viewed from a perspective of the entire budget and the economy, the growth of Medicare spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into a future without making changes in Social Security, Medicare and Medicaid Programs is to envision a very different role for the Federal Government for future generations.

As noted in the next exhibit on the left, Exhibit 3, even assuming that all projected surpluses are saved and discretionary budget caps are complied with—which many if not most believe are not realistic assumptions—our long-term budget simulation model shows the world in 2030, whereby Social Security, Medicare and Medicaid

increasingly absorb larger available resources in the Federal budget and they start to haircut other discretionary spending.

If, on the other hand, as noted on the right, the surplus is not saved and the unified surplus is spent, then based upon projected growth in Medicare and other health care programs, virtually the entire discretionary spending portion of the Federal budget will be scalped. And the discretionary spending portion of the budget includes national defense, the young, infrastructure, and law enforcement.

Now, realistically, spending is going to be made in those programs. The point here is, there are tremendous pressures on the mandatory part of the budget, largely fueled by known demographic trends, primarily but not exclusively health care issues, and Medicare is a major part of it.

Given the size of Medicare's unfunded liability, it is realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. 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, with retirees now representing a smaller portion of our population and before the baby boom generation, my generation, begins to retire.

Ideally, the unfunded promises associated with today's programs should be addressed before or concurrent with proposals to make new ones, such as adding prescription drug coverage. To do otherwise might be politically attractive but not fiscally prudent.

If 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 to establish expenditure or funding thresholds that would trigger a call for fiscal action.

Our history shows that when 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 ensure its sustainability, which is more important than solvency.

Proposals to reform Medicare should be assessed against the following criteria: affordability, equity, adequacy, feasibility, and acceptability. People want unfettered access to health care, and some have needs that are not being met. However, health care costs compete with other legitimate priorities 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 the Nation can collectively afford. This concept applies to all aspects of government, from major weapons system acquisitions to issues involving domestic programs, most importantly health care, because wants are unlimited, needs are different, and there are very real limits on what we can afford.

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.

A useful discussion of reform has been initiated. In March, the Bipartisan Commission on the Future of Medicare completed its deliberations, and in July the President proposed certain reforms. These options have spurred other proposals as well as discussions on the future of Medicare.

The details of any reform plan need to be specified before it can be fully evaluated. Both of the major plans, Breaux-Thomas and the President's plan, leave important details left unsaid, and they are important to be filled in, in order to assess their impact on sustainability of the Medicare Program as well as feasibility of adopting the proposals.

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 they inherit, to provide a strong foundation for future economic growth, and to get on with substantive entitlement reform in order to ensure that future commitments are both adequate and affordable. To do so, the Congress will need to address, as I said, the difference between wants, needs and affordability in connection with anything from weapons systems to health care. This is tough work, but it must be done.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions after my colleagues have a chance to make theirs.

[The prepared statement follows:]

Statement of Hon. David M. Walker, Comptroller General, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you discuss efforts to reform the administration, structure, and financing of Medicare—steps essential to maintaining the program's long-term solvency and to its modernization. There appears to be an emerging consensus that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. The long-term cost pressures facing this program are considerable. 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.

Against this backdrop, I want to acknowledge your efforts, Mr. Chairman, as well as the contributions of the other members of the Bipartisan Commission on the Future of Medicare. The Breaux-Thomas proposal, which grew out of the Commission's deliberations, included a comprehensive reform plan on a technically difficult issue that touches on both the future health of beneficiaries and the fiscal health of the U.S. economy.[1] I also want to commend both this Subcommittee and the Congress as a whole for remaining steadfast in the face of intense pressure to roll back the Medicare payment reforms included in the Balanced Budget Act of 1997 (BBA). It is in no sense hyperbole to note that the BBA changes constituted a critical down payment for Medicare reform. I know that the Subcommittee appreciates the vital importance of waiting for strong evidence that demonstrates the need for any modifications before acting.

You must be especially prudent during this period of prosperity as you consider Medicare reform initiatives. Please remember that, even as recent estimates have

[1] The National Bipartisan Commission on the Future of Medicare held its last meeting on March 16, 1999. By a vote of 10 to 7, the Commission failed to achieve the 11-member super majority required by law to report a recommendation to the Congress.

increased the size of budget surpluses, 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 appropriate caution should be exercised when creating new entitlements that establish permanent claims on future resources. While I do not relish being the accountability cop at the surplus celebration party, that is part of my job as Comptroller General of the United States.

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 would like to make a few summary points before delving into the specifics of Medicare's financial health and a discussion of potential reform.

• In March, the Bipartisan Commission on the Future of Medicare completed its deliberations. Reform options emerged from these and other discussions that touched on all aspects of the Medicare program, including (1) modernization of the traditional Medicare fee-for-service program, both to update the benefit package and enhance its potential for containing program costs; (2) modernization of the Medicare+Choice program to ensure that beneficiaries have health plan choices and allow the program to more efficiently purchase plan services; and (3) adoption of a program like the Federal Employees Health Benefits Program (FEHBP) or a premium support model to foster quality and price based competition among health plans and to elevate beneficiaries' consciousness about and responsibility for program costs.

• Given the size of Medicare's unfunded liability, it is realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. 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" with retirees 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, such as adding prescription drug coverage. To do otherwise might be politically attractive but not fiscally prudent. If benefits are added, policy makers need to consider targeting strategies that fully offset the related costs. They may also want to design a mechanism to monitor aggregate program costs over time and to establish expenditure or funding thresholds that would trigger a call for fiscal action. Our history shows that when 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.

• To qualify as meaningful reform, a proposal should make a significant down payment toward ensuring Medicare's long-range financial integrity and sustainability—the most critical issue facing Medicare. 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 is balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances. 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

Criterion	What this means for a proposal
Affordability	A proposal should be evaluated in terms of its effect on the long-term sustainability of Medicare expenditures
Equity	A proposal should be fair to providers and across groups of beneficiaries

Table 1.—Criteria for Assessing the Merits of Medicare Reform Proposals—Continued

Criterion	What this means for a proposal
Adequacy	A proposal should include resources that allow appropriate access and provisions that foster cost-effective and clinically meaningful innovations that address patients' needs
Feasibility	A proposal should incorporate elements that facilitate effective implementation and adequate monitoring
Acceptance	A proposal should be transparent and should educate provider and beneficiary communities about its costs and the realities of tradeoffs required by significant policy changes

• People want unfettered access to health care, and some have needs that are not being met. However, health care costs compete with other legitimate priorities 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 issues affecting domestic programs. 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.

• Let's not kid ourselves—reforming Medicare is hard work. 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. The Health Care Financing Administration (HCFA) estimates that the program's billers—physicians, hospitals, equipment suppliers, and other providers of health services—number about 1 million.

• As the various reform options come under scrutiny, the importance of design details should not be overlooked. Our work on efforts to implement reforms mandated in the BBA is instructive regarding reform specifics. Three principal lessons can be drawn from recent experience: (1) The particulars of payment mechanisms largely determine the extent to which a reform option can eliminate excess government spending while protecting beneficiaries access' to care. (2) Revisions to newly implemented policies should be based on a thorough assessment of their effects so that, at one extreme, they are not unduly affected by external pressures and premature conclusions or, at the other extreme, they remain static when change is clearly warranted. (3) For choice-based models to function as intended—that is, to foster competition based on cost and quality—consumers must have information that is sufficiently comparable.

At this time, I would like to discuss the competing concerns at the crux of Medicare reform, in general, and to provide a conceptual framework for considering the various possible combinations of reform options, in particular.

Competing Concerns Pose Challenges for Medicare Reform

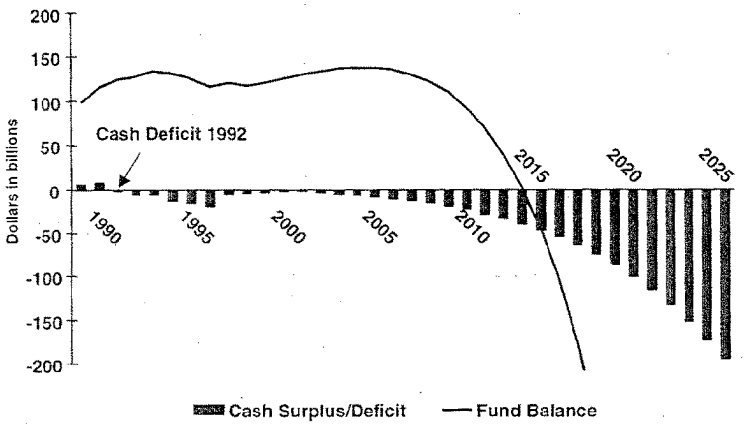
The current Medicare program, without improvements, is ill suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen 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 compared to private employer 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 all these parties requires hard choices that have been brought before this Subcommittee, the Congress, and the National Bipartisan Commission on the Future of Medicare.

Medicare Is Already in the Red

Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare Hospital Insurance (HI) Trust Fund—which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health

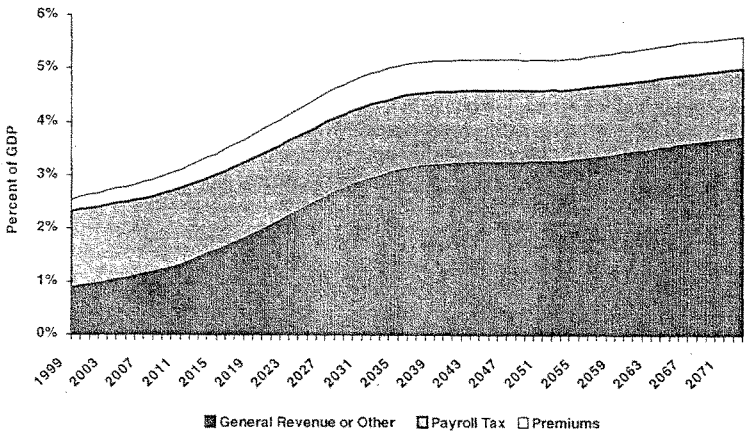
services—is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays. In serving the tracking purpose, annual trust fund reports show that Medicare's HI component is, on a cash basis, in the red and has been since 1992. (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 (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, 1990 to 2025



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), 1999 to 2071

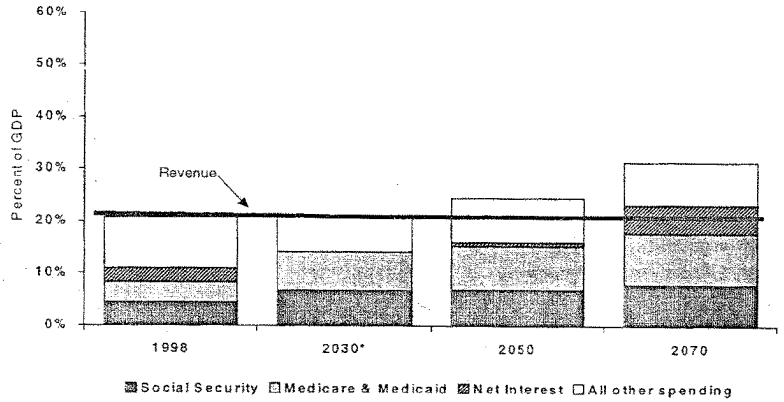


The progressive absorption of a greater share of the nation's resources for health care, like Social Security, is in part a reflection of the rising share of elderly in the population. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom. Today's elderly 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 declines from 3.4 to one today to roughly two to one.

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

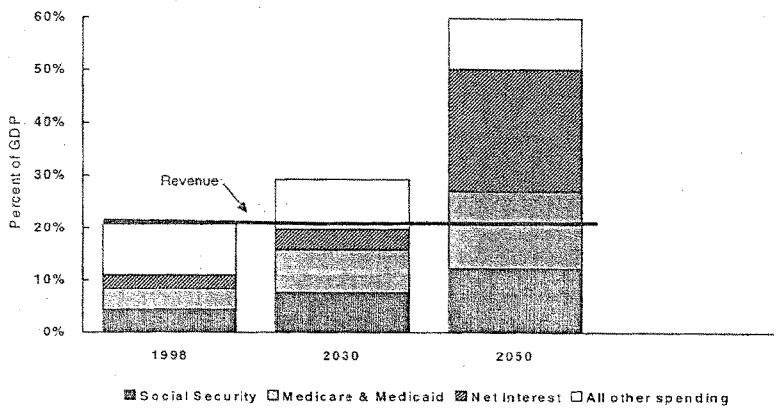
When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into the future without making changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. 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. In short, there will be essentially no discretionary programs at all.

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



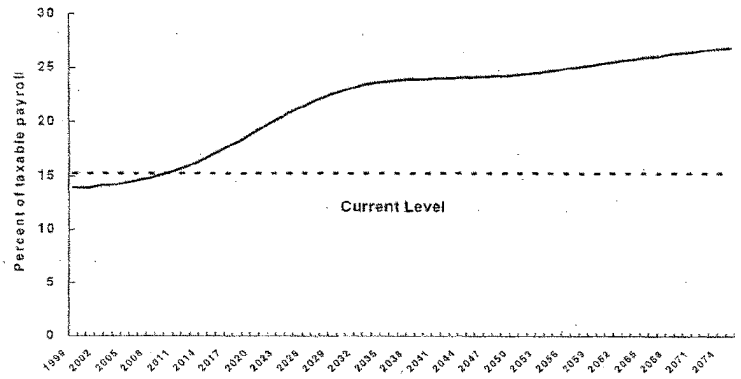
*In 2030, all other spending includes offsetting interest receipts.

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.

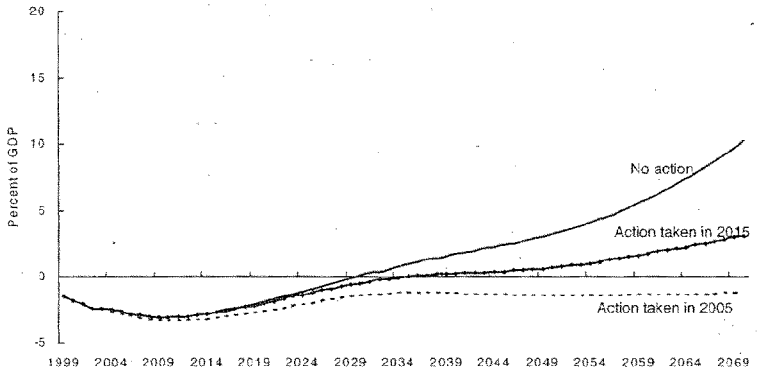
Figure 5: Social Security and Medicare HI as a Percent of Taxable Payroll, 1999 to 2074



While the problems facing the Social Security program are significant, Medicare's challenges are even more daunting. To close Social Security's deficit today would require a 17 percent increase in the payroll tax, whereas the HI payroll tax would have to be raised 50 percent to restore actuarial balance to the trust fund. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

Early action to address the structural imbalances in Medicare is critical. First, ample time is required to phase in the reforms 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, illustrate how critical early action on Medicare reform is to our long-term fiscal future. If the annual growth in per person Medicare spending could be slowed to 4 percent over the 70-year period it would yield the kind of savings needed to establish a truly sustainable budget policy for the long term. This is not easy however. Although over 70 years the projected average annual growth in per person spending is 4.5 percent, over the next 10 years it is nearly 5 percent. The high projected growth of Medicare in the coming years, means that the earlier the reform begins, the greater the savings will be as a result of the effects of compounding. Reforms fully phased in by 2005 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, 1999 to 2069



The actions necessary to bring about a more sustainable program will no doubt call for some hard choices. Some suggest that the size of the imbalances between

Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional resources. One possible source could be general revenues. Although this may eventually prove necessary, such additional financing should be considered as part of a broader initiative to ensure the program's long-range financial integrity and sustainability.

What concerns me most is that devoting general funds to the HI may be used to extend HI's solvency without addressing 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 economic 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 Medicare's promised benefits—both now and in the future.

If more fundamental program reforms are not made, I fear that general fund infusions 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 dedicating general funds to the HI program will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program. 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.

Long-Term Fiscal Policy Choices

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our nation's future capacity to afford paying benefits in the face of an aging society. Decisions on how we use today's surpluses can have wide-ranging impacts on our ability to afford tomorrow's commitments.

As we know, there have been a variety of proposals to use the surpluses for purposes other than debt reduction. Although these proposals have various pros and cons, we need to be mindful of the risk associated with using projected surpluses to finance permanent future claims on the budget, whether they are on the spending or tax side.[2] Commitments often prove to be permanent while projected surpluses can be fleeting. For instance, current projections assume full compliance with tight discretionary spending caps. Moreover, relatively small changes in economic assumptions can lead to very large changes in the fiscal outlook, especially when carried out over a decade. In a recent report, the Congressional Budget Office (CBO) compared the actual deficits or surpluses for 1988 through 1998 with the first projection it had produced 5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO says that its errors averaged about 13 percent of actual outlays. Such a shift in 2004 would mean a potential swing of about $250 billion in the projected surplus.

Although most would not argue for devoting 100 percent of the surplus to debt reduction over the next 10 years, saving a good portion of our surpluses would yield fiscal and economic dividends as the nation faces the challenges of financing an aging society. Our work on the long-term budget outlook illustrates the benefits of maintaining surpluses for debt reduction. Reducing the publicly held debt reduces interest costs, freeing up budgetary resources for other programmatic priorities. For the economy, running surpluses and reducing debt increase national saving and free up resources for private investment. These results, in turn, lead 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.[3] 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 all or most 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.

BBA Made Medicare Reform Down Payment

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[2] See *Federal Budget: The President's Midsession Review* (GAO/OCG–99–29, July 21, 1999).

[3] 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).

In addition to its significant financial imbalance, Medicare is outmoded from a programmatic perspective. 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. Nevertheless, BBA reforms enacted in 1997 have begun to address certain programmatic shortcomings by modernizing the program's pricing and payment strategies and by moving toward quality-based competition among health plans. The act's combination of structural reforms, constraints on provider fees, and increases in beneficiary payments was expected to lower program spending by $386 billion over 10 years. Because certain key provisions have only recently or have not yet been phased in, the full effects of the BBA on providers, beneficiaries, and taxpayers will not be known for some time.

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

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

Yet pressures mount to undo some of these changes. Affected providers are currently seeking to repeal various BBA provisions, some relying on anecdotal evidence rather than systematic analysis to make their case. An illustration is the reporting of health plan withdrawals from the Medicare+Choice program for 1999. Plans cite, and the press reports, inadequate payment rates as the reason for dropping out of Medicare or reducing enrollees' benefits. We have 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 report, we noted that BBA has reduced, but not eliminated, excess payments.[4] In fact, Medicare's payments to some plans are generous enough for plans to make profits and to finance prescription drugs and other extras not available to the majority of senior and disabled beneficiaries who remain in traditional Medicare. We have also reported that factors additional to or even exclusive of payment rates—including competition and other market conditions—played a significant role in the 1999 plan dropouts.[5] Our ongoing analysis of the year 2000 plan dropouts reveals similar findings. The question this raises for policymakers is the extent to which they should 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 similar ones 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 Subcommittee and the Congress as a whole face in making Medicare payment reforms.

Dimensions of Reform Include Benefit Expansions and Financing Changes

Concern continues to be voiced about the obvious gaps in protections for Medicare beneficiaries, in contrast to what is available for most individuals with private employer-based coverage. At the same time, competing concerns remain about the need to check Medicare's cost growth, even without adding new benefits. In response, the

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

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

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

Table 2.—Major Dimensions of Medicare Reform, by Option

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

Benefit Expansion Reforms

Medicare's basic benefit package largely reflects the offerings of the commercial insurance market in 1965 when the program began. Although commercial policies have evolved since then, Medicare's package—for the most part—has not.[6] For example, unlike many current commercial policies, Medicare does not cover outpatient prescription drugs or cap beneficiaries' annual out-of-pocket spending. Some beneficiaries can augment their coverage by participating in the Medicaid program (if their incomes are low enough), obtaining a supplemental insurance policy privately or through an employer, or enrolling in a Medicare+Choice plan. However, these options are not available to or affordable for all beneficiaries. Furthermore, to the extent that Medicaid and supplemental policies provide first-dollar coverage of services, the beneficiary population's sensitivity to service costs is dulled, contributing to some continued excess utilization. Consequently, many reform advocates believe that Medicare's basic benefit package should be brought into line with current commercial norms for active workers.

Two benefit reforms under discussion by policymakers are the inclusion of prescription drugs and stop-loss coverage that caps beneficiary out-of-pocket spending. Each involves myriad options, and assessing the merit of these reforms would depend on the specifics included. For instance, a Medicare prescription drug benefit could be targeted to provide coverage for all beneficiaries, coverage only for beneficiaries with extraordinary drug expenses, coverage only for low-income beneficiaries, or coverage for selected drugs, such as those deemed to be cost beneficial. Such coverage decisions would hinge on understanding how a new pharmaceutical benefit would shift to Medicare portions of the out-of-pocket costs borne by beneficiaries as well as those costs paid by Medicaid, Medigap, or employer plans covering prescription drugs for retirees. How would these new program costs be shared between taxpayers and beneficiaries through premiums, deductibles, and copayments? Would subsidies be provided to help low-income beneficiaries not eligible for Medicaid with these costs? The administration of the benefit raises other questions, such as, Who would set and enforce drug coverage standards among the private health plans participating in Medicare? And, for traditional Medicare, How would reimbursable prices be set? Price-setting options include using a formula based on market prices, negotiating directly with manufacturers, or contracting with pharmaceutical benefit management companies. The Breaux-Thomas proposal favored targeting a drug benefit to low-income beneficiaries while allowing those at higher incomes to buy into the benefit. A catastrophic, or stop-loss, coverage benefit would similarly entail its own design permutations and variables.

Financing and Other Structural Reforms

Many Medicare reforms are designed to slow spending growth to keep the program viable for the nation's growing aged population. Although the various proposals, including those considered by the Bipartisan Commission, differ from one another in concept, they generally include mechanisms to make beneficiaries more cost conscious, and incorporate provider incentives to improve the efficiency of

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

health care delivery. The various financing and structural reforms consist of components of three general models: fee-for-service modernization, Medicare+Choice modernization, and a premium support system fashioned after FEHBP (see Table 3).

Table 3.—Three Medicare Financing and Structural Reforms

	Fee-for-service modernization	Medicare+Choice modernization	FEHBP-type premium support
Pending under BBA ...	Prospective payment systems for HHAs, hospital outpatient departments, and others.	Health-based risk adjustment of rates. Annual enrollment and lock-in. Competitive pricing demonstration.	
Potential under current proposals.	Selective purchasing Negotiated pricing ..... Case management for complex and chronic conditions. Utilization management. Medigap and beneficiary cost-sharing reforms. Expanded use of centers of excellence.	Plan savings shared with program and/or beneficiaries. Competitive premium pricing.	Premium based on offered or negotiated price Beneficiary contribution based on plan cost Traditional Medicare incorporated Enhanced flexibility Self-financed

Fee-for-Service Modernization

BBA improved the efficiency of Medicare's traditional fee-for-service program by substituting a variety of PPSs and other fee changes for its cost-based reimbursement methods and outdated fees. Nevertheless, Medicare is still not an efficient purchaser. Adjusting its systems of administered prices and fees up or down to ensure beneficiary access or to capture potential savings as the market changes poses an overwhelming, if not impossible, challenge. Medicare largely remains a passive bill payer, exercising little meaningful control over the volume of services used. Proposals to modernize fee-for-service Medicare aim at providing flexibility to take advantage of market prices and introducing some management of service utilization. In proposing to make fee-for-service more fiscally accountable and to provide it with additional flexibility to achieve these fiscal goals, the Bipartisan Commission also discussed fee-for-service modernization as one of the critical elements of reform.

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

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

Private indemnity insurers have moved to incorporate certain utilization management techniques into their policies, such as prior authorization of some expensive services and case management for persons with serious chronic conditions. Although

such techniques are increasingly common among private insurers, their effectiveness on the population Medicare covers is unknown.

Medicare+Choice Modernization

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

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

The design of the Medicare+Choice program does not, however, allow taxpayers to benefit from the current competition among health plans. If a plan can provide the Medicare package of benefits for less than the Medicare payment, it must cover additional benefits, reduce fees, or both.[7] Plans that offer enriched benefit packages—such as including coverage for outpatient prescription drugs or routine physical examinations—may attract beneficiaries and gain market share. Medicare, however, pays the predetermined price even in fiercely competitive markets.

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

FEHBP-Type Premium Support

Although modernizing traditional Medicare and Medicare+Choice could improve the control of program spending, several incentives would remain unaltered. For example, beneficiaries would remain partially insulated from the cost consequences of their choices. They would not benefit directly from selecting plans capable of delivering Medicare-covered benefits less expensively because the premiums they pay might well remain constant. Program payments to plans would continue to be established administratively. The Breaux-Thomas proposal recognized beneficiary sensitivity to cost as the critical element missing from the current Medicare program. To remedy this situation, the Breaux-Thomas proposal and others have proposed the adoption of an FEHBP-type premium support for Medicare—a mechanism that could, at the same time, serve to increase beneficiary sensitivity to the cost consequences of their choices and enhance quality/cost based competition.

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

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

Because most beneficiaries participate—and are expected to continue to participate—in traditional fee-for-service Medicare, its incorporation into the FEHBP-type system is seen as important. Under current arrangements, the only premium for participating in the traditional program is the fixed monthly amount that beneficiaries voluntarily pay to receive coverage for SMI or to be eligible to enroll in a Medicare+Choice plan. Because the premium amount represents only 25 percent of the program's cost and is deducted from beneficiaries' monthly Social Security payments, participants are not as aware of the cost of the traditional Medicare program. The Breaux-Thomas proposal incorporates traditional Medicare as another plan under an FEHBP-type premium support system. Traditional Medicare would propose and negotiate premiums like any other plan and be expected to be self-financing and self-sustaining. Recognizing the challenge the latter requirement creates, the proposal would also provide traditional Medicare more flexibility to manage costs using tools similar to proposals for fee-for-service modernization.

Incorporating traditional Medicare as another plan puts all plans on equal footing and maximizes beneficiaries awareness of costs. However, the sheer size of the traditional program creates questions. How much flexibility can be granted to traditional Medicare, given its market power? What will it mean for a public plan to be self-sustaining and self-financing? Can it generate and retain reserves as a protection against future losses? How will losses be managed? The insolvency of traditional Medicare, which may continue to enroll the majority of beneficiaries and may be the only plan serving many areas of the country, is not acceptable. The dilemma of how to guarantee traditional Medicare's solvency in the context of an FEHBP-type premium support system needs to be addressed.

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

CONCLUDING OBSERVATIONS

In determining how to reform the Medicare program, much is at stake—not only the future of Medicare itself but also assuring the nation's future fiscal flexibility to pursue other important national goals and programs. Mr. Chairman, I feel that the greatest risk lies in doing nothing to improve the program's long-term sustainability or, worse, in adopting changes that may aggravate the long-term financial outlook for the program and the budget.

It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Relieving them of some of the burden of today's financing commitments would help fulfill this generation's fiduciary responsibility. It would also preserve some capacity to make their own choices by strengthening both the budget and the economy they inherit. While not ignoring today's needs and demands, we should remember that surpluses can be used as an occasion to promote the transition to a more sustainable future for our children and grandchildren.

General fund infusions and expanded benefits may well be a necessary part of any major reform initiative. Updating the benefit package may be a necessary part of any realistic reform program to address the legitimate expectations of an aging society for health care, both now and in the future. Such changes, however, need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. In addition, the Congress should consider adequate fiscal incentives to control costs and a targeting strategy in connection with any proposal to provide any new benefit such as prescription drugs.

I am under no illusions about how difficult Medicare reform will be. The Breaux-Thomas proposal addresses the principal elements of reform, but many of the details need to be worked out. Those details will determine whether reforms will be both effective and acceptable—that is, seen as guaranteeing the sustainability and preservation of the Medicare entitlement, a key goal on which there appears to be consensus. Experience shows that forecasts can be far off the mark. Benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. 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 workforce is relatively large. National saving pays future dividends over the long term but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead time to phase in changes and before the changes that are needed become dramatic and disruptive. The prudent use of the nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

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

GAO CONTACTS AND ACKNOWLEDGMENTS

If you have any questions regarding this testimony, please call Paul L. Posner, Director of Budget Issues, at (202) 512–9573 or William J. Scanlon, Director of Health Financing and Public Health at (202) 512–7114. Other individuals who made key contributions include Linda F. Baker, James Cosgrove, Hannah F. Fein, James R. McTigue, Walter Ochinko, and Deborah Spielberg.

Chairman THOMAS. Thank you very much, Mr. Walker.

And given the structuring, why don't we just start, Dr. Moon, with you, and then we will swing this way and wind up with the gentleman, if that is OK. And any written testimony you have will be made a part of the record, and you can address this in any way you see fit in the time you have.

STATEMENT OF MARILYN MOON, PH.D., SENIOR FELLOW, URBAN INSTITUTE

Ms. MOON. Thank you, Mr. Thomas. It is a privilege to be here this afternoon and address your Committee.

I would like to talk a little bit about some of the concerns I have with the restructuring proposals that people are discussing now, and to try to put them into some context in terms of understanding both whether or not the solution fits the problem, and what some of the issues in terms of protections that I believe should be extended to beneficiaries need to be in place if we are going to move in this direction.

Projected increases in Medicare spending arise because of the high costs of health care and because growing numbers of persons will be eligible for the program. Further, the primary reason for higher costs over time is technological change and increased improvements in the health care system, a phenomenon that is occurring system-wide and not just in Medicare.

But both of these reasons for higher spending are not necessarily solved by proposals to restructure Medicare. Claims for savings from options that shift Medicare more to a system of private insurance usually rest on two basic arguments, first, that the private sector is per se more efficient than Medicare; and, second, that competition among plans will generate more price sensitivity on the part of beneficiaries and plans alike.

In the chart that you have already discussed to some extent here, I looked back over the last 27 years, starting in 1970 when the National Health Expenditure Accounts really set up a consistent series to look at. And also in the early years it is interesting that both Medicare and private insurance were largely just pass-through systems, where they were just paying the bills and not much was being done to manage health care.

Over this 27-year period, though, Medicare's performance in terms of growth in the costs of care has been better than that of private insurance, largely because Medicare started early on in the eighties to be serious about cost containment efforts and made substantial improvements at that point in time.

To date, most of the cost savings generated by all payers of care has come from slowing growth in the prices paid for services and making only preliminary inroads in reducing the use of services or addressing the issue of technology. Reining in the use of services will constitute a major challenge for both private insurance and Medicare in the future, and I think it is not clear whether the public or private sector is better able to do this.

The other way in which people talk about saving money through restructuring the Medicare Program is by requiring that beneficiaries who choose higher cost plans pay substantially higher premiums, and here there is some evidence from Calpers and the FEHBP program that that does have some impact on the costs of care. I think the question for Medicare is whether or not beneficiaries of this program will operate in the same way as younger persons have operated in the FEHBP and Calpers systems, and you can look to a number of other places, such as the California retirement system for the university, where retirees have not behaved in the same way as the younger population, so there is some concern here.

Moreover, new approaches to the delivery of health care under Medicare may generate a whole set of problems, including problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients. It is disruptive and can raise the cost of care. And if it is only the healthier beneficiaries who choose to switch plans, the sickest and most vulnerable beneficiaries will end up being concentrated in plans that become increasingly expensive over time.

I believe there are also some critical protections that exist in the Medicare Program now, that would need to be rethought and redone if we moved primarily to a private system. That is protecting the universality and redistribution that occurs in Medicare; the pooling of risks that occurs in the current Medicare system; and recognizing that there are protections that the Government has traditionally provided. So these are issues that I think are par-

ticularly important and must be part of a reform system if we move in that direction.

What are the tradeoffs from increasingly relying on private plans to serve Medicare beneficiaries? The modest gains and lower costs that are likely to come from some increased competition, and from the flexibility that the private sector enjoys, could be more than offset by the loss of social insurance protection. In addition, not all the consequences of a competitive market are positive. For example, some plans will not do well in a particular market, and as a result they will leave, creating the same kinds of disruptions that people have been very upset about in terms of the withdrawals from the Medicare Plus Choice program that have been recently announced.

Rather than focusing on restructuring Medicare to emphasize private insurance, I would place emphasis on innovations necessary for improvements in health care delivery regardless of setting, and many of these, such as improvements in the standards and norms of care, protection for individuals' information, can be better done often in a public setting than in a private setting.

Finally, Medicare as a default plan, as the traditional program, needs to get a lot of attention and care. As people have already mentioned, it will continue to be a major part of this program, and I think a considerable amount of emphasis needs to go there, to improve that program.

Thank you.

[The prepared statement follows:]

Statement of Marilyn Moon, Senior Fellow, Urban Institute

The aging of the U.S. population will generate many challenges in the years ahead, but none more dramatic than the costs of providing health care services for older Americans. Largely because of advances in medicine and technology, spending on both the old and the young has grown at a rate faster than spending on other goods and services. Combining a population that will increasingly be over the age of 65 with health care costs that will likely continue to rise over time is certain to mean an increasing share of national resources devoted to this group. How will the burden of that expense be shared over time and what role will Medicare play in meeting these needs?

Projections from the 1999 Trustees Report indicate that Medicare's share of the Gross Domestic Product (GDP) from both parts of the program will reach 4.43 percent in 2025, up from 2.53 percent in 1998. This projection is lower than just a few years ago, however. For example, the estimates of the date of exhaustion of the Part A Trust fund have been pushed out to 2015. While this new date of exhaustion reduces some of the perceived urgency in addressing the issue, it is important not to underestimate the need for addressing reforms and financing issues for Medicare. This reprieve in the deadline for action offers an opportunity to engage in a careful discussion of the issues surrounding Medicare that extends beyond the budgetary focus that has thus far dominated much of the debate. Action is needed, but there is time to do it deliberately.

THE FOCUS ON STRUCTURAL REFORMS

Projected increases in Medicare's spending arise because of the high costs of health care and growing numbers of persons eligible for the program. But most of the debate over Medicare reforms centers on only a piece of the cost issue. That is, changes to reduce Medicare spending through restructuring can only go so far. Technological advances that raise the costs of care are the primary reason for higher costs over time, and this phenomenon is occurring system wide, not just in Medicare. Further, a beneficiary population that is growing now because of increased life expectancy and will be exacerbated in the future by the retirement of the baby boom raises issues well beyond any restructuring options. Nonetheless, restructuring could profoundly affect Medicare's future.

Claims for savings from options that shift Medicare more to a system of private insurance usually rest on two basic arguments: first, it is commonly claimed that the private sector is per se more efficient than Medicare, and second, that competition among plans will generate more price sensitivity on the part of beneficiaries and plans alike. What about these claims?

Medicare vs. *the Private Sector*: Looking back over the last 27 years (between 1970 and 1997), Medicare's performance in terms of growth in the costs of care has been better than that of private insurance. Starting in the 1970s, Medicare and private insurance plans initially grew very much in tandem, showing few discernible differences (See Chart 1). By the 1980s, per capita spending had more than doubled in both sectors. But Medicare became more proactive than private health insurance in the 1980s, and cost containment efforts, particularly through hospital payment reforms, began to pay off. From about 1984 through 1988, Medicare's per capita costs grew much more slowly than those in the private sector.

This gap in overall growth in Medicare's favor stayed relatively constant until the early 1990s when private insurers began to take seriously the rising costs of health insurance. At that time, growth in private insurance moderated in a fashion similar to Medicare's slower growth in the 1980s. Thus, it can be argued that the private sector was playing "catch up" to Medicare in achieving cost containment. Private insurance thus narrowed the difference with Medicare in the 1990s, but as of 1997, there was still a considerable way for the private sector to go before its cost growth would match Medicare's achievement of lower overall growth.

It should not be surprising that the per capita rates over time are similar between Medicare and private sector spending since all health care spending shares technological change and improvement as a major factor driving high rates of expenditure growth. To date, most of the cost savings generated by all payers of care has come from slowing growth in the prices paid for services and making only preliminary inroads in reducing the use of services or addressing the issue of technology. Reining in use of services will constitute a major challenge for both private insurance and Medicare in the future, and it is not clear whether the public or private sector is better equipped to do this. Further, Medicare's experience with private plans has been a distinctly mixed.

Using Competition to Generate Savings: Reform options such as the premium support approach seek savings by allowing the premiums paid by beneficiaries to vary such that those choosing higher cost plans pay substantially higher premiums. The theory is that beneficiaries will become more price conscious and choose lower cost plans. This in turn will reward private insurers that are able to hold down costs. And there is some evidence from the federal employees system and the Calpers system in California that this has disciplined the insurance market to some degree. Studies that have focused on retirees, however, show much less sensitivity to price differences. Thus, what is not known is how well this will work for Medicare beneficiaries.

For example, for a premium support model to work, at least some beneficiaries must be willing to shift plans each year (and to change providers and learn new rules) in order to reward the more efficient plans. Without that shifting, savings will not occur. In addition, there is the question of how private insurers will respond. Will they seek to improve service or instead focus on marketing and other techniques to attract a desirable, healthy patient base? It is simply not known if the competition will really do what it is supposed to do.

In addition, new approaches to the delivery of health care under Medicare may generate a whole new set of problems, including problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients; it is not only disruptive, it can raise costs of care. Some studies have shown that having one physician over a long period of time reduces costs of care. And if it is only the healthier beneficiaries who choose to switch plans, the sickest and most vulnerable beneficiaries may end up being concentrated in plans that become increasingly expensive over time. The case of retirees left in the federal employees high option Blue Cross plan and in a study of retirees in California suggest that even when plans become very expensive, beneficiaries may be fearful of switching and end up substantially disadvantaged. Further, private plans by design are interested in satisfying their own customers and generating profits for stockholders. They cannot be expected to meet larger social goals; and to the extent that such goals remain important, reforms in Medicare will have to incorporate additional protections to balance these concerns as described below.

WHAT IT IS CRUCIAL TO RETAIN FROM MEDICARE

The reason to "save" Medicare is to retain for future generations the qualities of the program that are valued by Americans and that have served them well over the last 33 years. This means that any reform proposal ought to be judged on principles that go well beyond the savings that they might generate for the federal government.

In this testimony I stress three crucial principles that are integrally related to Medicare's role as a social insurance program:

- The universal nature of the program and its consequent redistributive function.
- The pooling of risks that Medicare has achieved to share the burdens across sick and healthy.
- The role of government in protecting the rights of beneficiaries—often referred to as its entitlement nature.

While there are clearly other goals and contributions of Medicare, these three are part of its essential core. Traditional Medicare, designed as a social insurance program, has done well in meeting these goals. What about options relying more on the private sector?

Universality and Redistribution: An essential characteristic of social insurance that Americans have long accepted is the sense that once the criterion for eligibility of contributing to the program has been met, that benefits will be available to all beneficiaries. One of Medicare's great strengths has been providing much improved access to health care. Before Medicare's passage, many elderly persons could not afford insurance, and others who could not obtain it were denied coverage as poor risks. That changed in 1966 and had a profound impact on the lives of millions of seniors. The desegregation of many hospitals occurred under Medicare's watch. And although there is substantial variation in the ability of beneficiaries to supplement Medicare's basic benefits that should be of concern, basic care is available to all who carry that Medicare card. Hospitals, physicians and other providers largely accept the card without question.

Once on Medicare, illness or high medical expenses no longer place enrollees in fear of losing care or battling to retain coverage with a private plan—a problem that still happens too often in the private sector. This assurance is an extremely important benefit to many older Americans and persons with disabilities. Developing a major health problem is not grounds for losing the card; in fact, in the case of the disabled, it is grounds for coverage. This is vastly different than the philosophy of the private sector towards health coverage. Even though many private insurers are willing and able to care for Medicare patients, the easiest way to stay in business as an insurer is to seek out the healthy and avoid the sick.

Will reforms that lead to a greater reliance on the market still retain the emphasis on equal access to care and plans? For example, differential premiums could undermine some of the redistributive nature of the program that assures even low income beneficiaries access to high quality care and responsive providers.

The Pooling of Risks: One of Medicare's important features is the achievement of a pooling of risks among the healthy and sick covered by the program. Even among the oldest of the beneficiaries, there is a broad continuum across individuals' needs for care. While some of this distribution is totally unpredictable (because even people who have historically had few health problems can be stricken with catastrophic health expenses), a large portion of seniors and disabled persons have chronic problems known to be costly to treat. If these individuals can be identified and segregated, the costs of their care can expand beyond the ability of even well-off individuals to pay over time.

A major impetus for Medicare was the need to protect the most vulnerable. That's why the program focused exclusively on the old in 1965 and then added the disabled in 1972. About one in every three Medicare beneficiaries has severe mental or physical health problems. In contrast, the healthy and relatively well-off (with incomes over $32,000 per year for singles and $40,000 per year for couples) make up less than 10 percent of the Medicare population. Consequently, anything that puts the sickest at greater risk relative to the healthy is out of sync with this basic tenet of Medicare. A key test of any reform should be who it best serves.

If the advantages of one large risk pool (such as the traditional Medicare program) are eliminated, other means will have to be found to make sure that insurers cannot find ways to serve only the healthy population. This is a very difficult challenge that has been studied extensively; as yet no satisfactory risk adjustor has been developed. What has been developed to a finer degree, however, are marketing tools and mechanisms to select risks. High quality plans that attract people with health care needs are likely to be more expensive than plans that focus on serving the relatively healthy. If risk adjustors are never powerful enough to eliminate

these distinctions and level the playing field, then those with health problems—who disproportionately have lower incomes—would have to pay the highest prices under many reform schemes.

The Role of Government: Related to the two above principles is the role that government has played in protecting beneficiaries. In traditional Medicare, this has meant having rules that apply consistently to individuals and assuring everyone in the program access to care. It has sometimes fallen short in terms of the variations that occur around the country in benefits, in part because of interpretation of coverage decisions but also because of differences in the practice of medicine. But in general, Medicare has to meet substantial standards and accountability that protect its beneficiaries.

If the day-to-day provision of care is left to the oversight of private insurers, what will be the impact on beneficiaries? It is not clear whether the government will be able to provide sufficient oversight to protect beneficiaries and assure them of access to high quality care. Particularly is an independent board is established, to whom will it be accountable. Further, what provisions will be in place to step in when plans fail to meet requirements or who leave an area abruptly? What recourse will patients have when they are denied care?

One of the advantages touted for private plans is their ability to be flexible and even arbitrary in making decisions. This allows private insurers to respond more quickly than a large government program and to intervene where they believe too much care is being delivered. But one plan's cost effectiveness activities may translate into a beneficiary's loss of potentially essential care. Which is more alarming, too much care or care denied that cannot be corrected later? Some of the "inefficiencies" in the health care system may be viewed as a reasonable response to uncertainty when the costs of doing too little can be very high indeed.

WHAT SHOULD BE THE DIRECTION FOR REFORM OF THE DELIVERY OF CARE?

Much of the debate over how to reform the Medicare program has focused on broad restructuring proposals. However, it is useful to think about reform in terms of a continuum of options that vary in their reliance on private insurance. Few advocate a fully private approach with little oversight; similarly few advocate moving back to 1965 Medicare with its unfettered fee-for-service and absence of any private plan options. In between, however, are many possible options and variations. And while the differences may seem technical or obscure, many of these "details" matter a great deal in terms of how the program will change over time and how well beneficiaries will be protected. Perhaps the most crucial issue is how the traditional Medicare program is treated. Is it just one of many plans that beneficiaries choose among, or does it remain the basic default option with private plans playing a comparable or larger role than under the current Medicare+Choice arrangement?

What are the tradeoffs from increasingly relying on private plans to serve Medicare beneficiaries? The modest gains in lower costs that are likely to come from some increased competition and from the flexibility that the private sector enjoys could be more than offset by the loss of social insurance protection. The effort necessary to create in a private plan environment all the protections needed to compensate for moving away from traditional Medicare seems too great and too uncertain. And, on a practical note, many of the provisions in the Balanced Budget Act of 1997 that would be essential in any further moves to emphasize private insurance—generating new ways of paying private plans, improving risk adjustment and developing information for beneficiaries, for example—still need a lot of work.

In addition, it is not clear that there is a full appreciation by policy makers or the public at large of all the consequences of a competitive market. Choice among competing plans and the discipline that such competition can bring to prices and innovation are often stressed as potential advantages of relying on private plans for serving the Medicare population. But, if there is to be choice and competition, some plans will not do well in a particular market and as a result they will leave. In a market system, withdrawals should be expected; indeed, they are a natural part of the process by which uncompetitive plans that cannot attract enough enrollees leave particular markets. If HMOs have a hard time working with doctors, hospitals and other providers in an area, they may decide that this is not a good market. And if they cannot attract enough enrollees to justify their overhead and administrative expenses, they will also leave an area. The whole idea of competition is that some plans will do well—and in the process drive others out of those areas. In fact, if no plans ever left, that would likely be a sign that competition was not working well. This will result in disruptions and complaints by beneficiaries—much like those now occurring surrounding the recently announced withdrawals from Medicare+Choice.

What I would prefer to see instead is emphasis on improvements in both the private plan options and the traditional Medicare program, basically retaining the current structure in which traditional Medicare is the primary option. Rather than focusing on restructuring Medicare to emphasize private insurance, I would place the emphasis on innovations necessary for improvements in health care delivery regardless of setting.

That is, better norms and standards of care are needed if we are to provide quality of care protections to all Americans. Investment in outcomes research, disease management and other techniques that could lead to improvements in treatment of patients will require a substantial public commitment. This cannot be done as well in a proprietary, for-profit environment where dissemination of new ways of coordinating care may not be shared. Private plans can play an important role and may develop some innovations on their own, but in much the same way that we view basic research on medicine as requiring a public component, innovations in health delivery also need such support. Further, innovations in treatment and coordination of care should focus on those with substantial health problems—exactly the population that many private plans seek to avoid. Some private plans might be willing to specialize in individuals with specific needs, but this is not going to happen if the environment is one emphasizing price competition and with barely adequate risk adjustors. Innovative plans would likely suffer in that environment.

Finally, the default plan—where those who do not or cannot choose or who find a hostile environment in the world of competition—must, at least for the time being, be traditional Medicare. Thus, there needs to be a strong commitment to maintaining a strong traditional Medicare program while seeking to define the appropriate role for alternative options. But for the time being, there cannot and should not be a "level playing field" between traditional Medicare and private plans. Indeed, if Medicare truly used its market power like other dominant firms in an industry, it could set its prices in markets in order to drive out competitors. It could sign exclusive contracts with providers, squeezing out private plans. When private plans suggest that Medicare should compete on a "level playing field," it is unlikely that they have such activities in mind, however.

OTHER REFORM ISSUES

While most of the attention on reform focuses on structural questions, there are other key issues that must also be addressed, including the adequacy of benefits, reforms that pass costs on to beneficiaries, and the need for more general financing. Even after accounting for changes that may improve the efficiency of the Medicare program through either structural or incremental reforms, the costs of health care for this population group will still likely grow as a share of GDP. That will mean the important issue of who will pay for this health care—beneficiaries, taxpayers or a combination of the two—must ultimately be addressed to resolve Medicare's future.

Improved Benefits: It is hard to imagine a "reformed" Medicare program that did not address two key areas of coverage: prescription drugs and a limit on the out-of-pocket costs that any individual beneficiary must pay in a year. Critics of Medicare rightly point out that its inadequacy has led to the development of a variety of supplemental insurance arrangements which in turn create an inefficient system in which most beneficiaries rely on two sources of insurance to meet their needs. Further, without a comprehensive benefit package that includes those elements of care that are likely to naturally attract sicker patients, viable competition without risk selection will be difficult to attain.

It is sometimes argued that improvements in coverage can only occur in combination with structural reform. And some advocates of a private approach to insurance go further, suggesting that the structural reform itself will naturally produce such benefit improvements. This implicitly holds the debate on improved benefits hostage to accepting other unrelated changes. And to suggest that a change in structure, without any further financial contributions to support expanded benefits, will yield large expansions in benefits is wishful thinking. A system designed to foster price competition is unlikely to stimulate expansion of benefits.

Expanding benefits is a separable issue from how the structure of the program evolves over time. It is not separable from the issue of the cost of new benefits, however. This is quite simply a financing issue and it would require new revenues, likely from a combination of beneficiary and taxpayer dollars. A voluntary approach to provide such benefits through private insurance, such as we have at present, is seriously flawed. Prescription drug benefits generate risk selection problems; already the costs charged by many private supplemental plans for prescription drugs equal or outweigh their total possible benefits because such coverage attracts a sicker

than average set of enrollees. A concerted effort to expand benefits is necessary if Medicare is to be an efficient and effective program.

Benefits and Eligibility Issues for Disability Beneficiaries: A number of special problems face the under–65 disabled population on Medicare. The 18 month waiting period before a Social Security disability recipient becomes eligible for coverage creates severe hardships for some beneficiaries who must pay enormous costs out of pocket or delay treatments that could improve their disabilities if they do not have access to other insurance. In addition, a disproportionate share of the disability population has mental health needs and Medicare's benefits in this area are seriously lacking. Special attention to the needs of this population should not get lost in the broader debate.

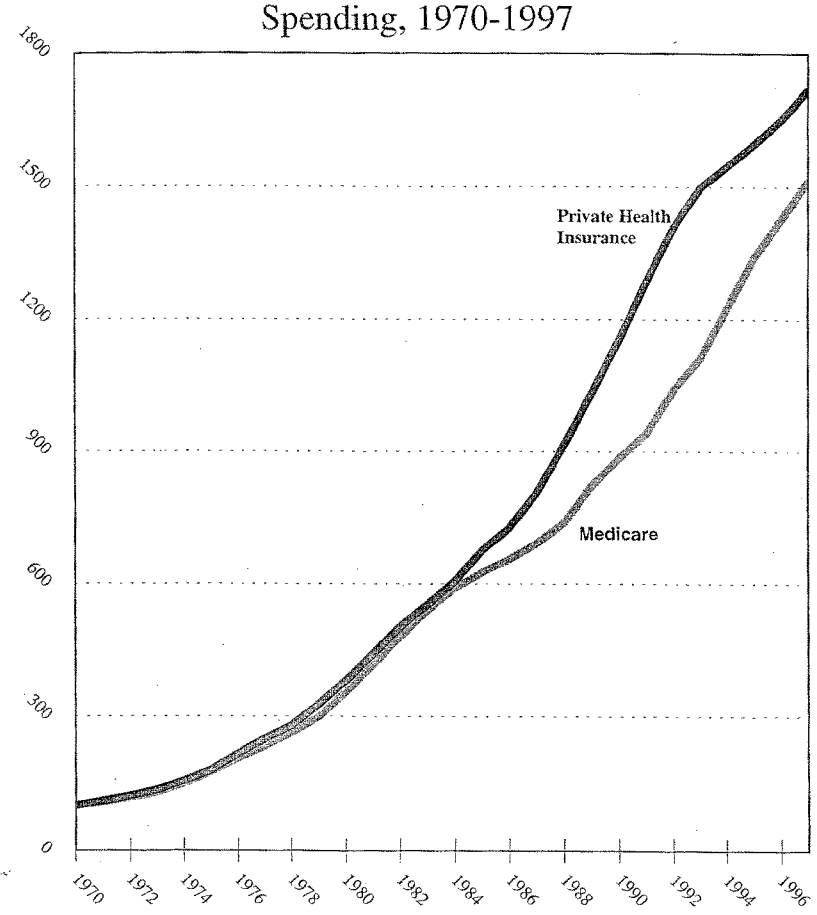
Beneficiaries' Contributions: Some piece of a long-term solution probably will (and should) include further increases in contributions from beneficiaries beyond what is already scheduled to go into place. The question is how to do so fairly. Options for passing more costs of the program onto beneficiaries, either directly through new premiums or cost sharing or indirectly through options that place them at risk for health care costs over time, need to be carefully balanced against beneficiaries' ability to absorb these changes. Just as Medicare's costs will rise to unprecedented levels in the future, so will the burdens on beneficiaries and their families. Even under current law, Medicare beneficiaries will be paying a larger share of the overall costs of the program and more of their incomes in meeting these health care expenses (see Chart 2).

In addition, options to increase beneficiary contributions to the cost of Medicare further increase the need to provide protections for low income beneficiaries. The current programs to provide protections to low income beneficiaries are inadequate, particularly if new premium or cost sharing requirements are added to the program. And the issue of whether such protections should be housed in the Medicaid program also needs further consideration.

Financing: Last, but not least, Medicare's financing must be part of any discussion about the future. We simply cannot expect as a society to provide care to the most needy of our citizens for services that are likely to rise in costs and to absorb a rapid increase in the number of individuals becoming eligible for Medicare without taking the financing issue head on. Medicare now serves one in every eight Americans; by 2030 it will serve nearly one in every four. And these people will need to get care somewhere. If not through Medicare, then where?

Chart 1

Cumulative Per Capita Rates of Growth in Health Care Spending, 1970-1997



Source: The Urban Institute's Analysis of National Health Expenditure Data

Chairman THOMAS. Thank you very much.
Dr. Wilensky.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE, BETHESDA, MARYLAND

Ms. WILENSKY. Thank you very much, Mr. Chairman and Members of the Subcommittee, for including me on this panel. I am here as a health policy person and economist rather than in my official position as MedPAC Chair, although I am going to draw on some of my experiences as having been Administrator of the Health Care Financing Administration in the early nineties.

I want to summarize with a few points. The first one has to do with the continuing need to reform. As the Comptroller General has indicated, there is a problem with regard to financial pressures. I know you have heard about this in the past.

Recently, in the spring, it was announced that there was an extra 5 years in terms of the time when the part A trust fund would go into bankruptcy. I only want to point out that those extra 5 years depend on razor-thin surpluses in each of the years in the early part of this next decade, and if for any reason they were to go away, either because expenditures go up just a little bit or income drops just a little bit because of an employment drop, those surpluses would disappear very quickly.

But at least as important as the solvency issues is the fact that there are other reasons to reform Medicare. The current benefit structure is inadequate, and, importantly, it is unfair.

We have heard from Members of your Committee the frustration that in some parts of the country far less is spent on Medicare than in other parts of the country, not because of cost-of-living differences or because of health status differences, but because of the way that health care is practiced or because of the demands of seniors. That is an issue that we need to address because it means that there is a lot of cross-subsidizing going on in this country from areas with conservative practice styles to areas with more aggressive practice styles.

As many of you know, I personally support a premium support model as a reform vehicle to address this, and the reason is because I believe it gives people choices between traditional Medicare as they have known it and other Medicare replacement plans, but more importantly, it rewards both the seniors who choose low-cost programs and also it rewards the physicians and other health care providers in providing them with better incentives.

Now, I know that not all Members of your Committee agree with this model, and so I want to also be clear that people understand that some of the most vexing issues with regard to premium support are present in our current system that allows for either traditional Medicare or Medicare replacement. And by that I mean risk adjustment, the need to educate seniors seriously so that they understand what they are choosing, and the issue about very different spending patterns across the country.

One of the areas that will need reform if we are to change the Medicare Program has to do with building an infrastructure and who or what agency is actually to administer that infrastructure. I support the notion of a Medicare board if we are to have a serious package of Medicare replacement programs along with the Health Care Financing Administration as the administrator of a traditional Medicare Program. And I say that with both affection and respect for what HCFA can do in terms of administering a traditional Medicare Program.

They have a clear focus and expertise, and that is in administering a public program with administered prices. And I think they most of the time, although I know occasionally you disagree, do a good job of running that program. But I think it is a conflict of interest, and it also draws far beyond their expertise to have them also be administering a set of insurance replacement pro-

grams. So my advice is that a Medicare board, or whatever you may choose to name it, would be better for administering the replacement programs and allowing HCFA to administer the traditional program.

Having said that, I think it is important that the Congress extend to HCFA more flexibility than it has tended to allow HCFA in the past. Its relationship with HCFA has been very micro-prescriptive, allowing very little flexibility. If you are serious about talking about a modernized fee-for-service, you will need to allow HCFA some of the authority that exists now with the private plans—centers of excellence, disease management, selective contracting, best practices, the kinds of things that HCFA cannot do.

A part of me was a little skeptical about whether HCFA will be able to get beyond its own bureaucratic inertia to make use of that flexibility, but we will not know and we will not see a modernized fee-for-service plan if you do not extend that additional flexibility.

Two points, and then I will close. The first is, reform will take some time. MedPAC, whenever we make recommendations, almost always recommends phasing in change. That is clearly true in terms of a major restructuring of Medicare. My advice is start now. It will take some time.

The second point I would like to leave with you is remember that tomorrow's seniors will be different, a different generation than today's seniors. Almost all of the women will have had working experiences for many of them, including those on the panel, all of our adult life. We will see many more people with assets that they have developed and some pension differences. And so while it is important to understand the needs and concerns of today's senior population, we do need to understand that the baby-boomer generation will be a different population and to plan for Medicare for the 21st century with that in mind.

Thank you.

[The prepared statement follows:]

Statement of Hon. Gail R. Wilensky, Ph.D., John M. Olin Senior Fellow, Project HOPE, Bethesda, Maryland

Let me summarize my points as follows:

- There is a continuing need to reform Medicare
  1. Solvency and financial pressures continue as important issues
  2. The current benefit structure is inadequate and unfair
- A premium support model is a reform vehicle to address these issues
  1. It rewards seniors choosing low-cost, efficient plans, allows seniors to choose plans that best suit their needs, and provides better incentives to physicians and other providers
  2. Many of the most vexing issues of premium support are also present with the current combination of fee-for-service Medicare and Medicare replacement plans
- Medicare reform will require a series of changes
  1. Reform should start now; building the infrastructure will take time
  2. Future seniors will be different from today's seniors in terms of work experiences, health plan experiences, income and education
- Premium support model requires a different institutional structure
  1. A Medicare Board, separate from HCFA, to oversee and negotiate with plans
  2. A Modernized FFS Medicare requires a different mind-set from HCFA and a more flexible relationship with the Congress

Mr. Chairman and members of the subcommittee, thank you for inviting me to appear before you. My name is Gail Wilensky. I am the John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I chair the

Medicare Payment Advisory Commission. I am also a former Administrator of the Health Care Financing Administration. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences running HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or MedPAC.

THE NEED FOR REFORM

Medicare's popularity as a social program notwithstanding, the program is in need of major reform. Although Medicare solved the primary problem it was designed to address, ensuring that seniors had access to health care, there are a variety of problems with Medicare as it is currently constructed.

Much of the motivation for Medicare reform has been financial. Medicare, as it is currently structured, is partially dependent on a Part A trust fund that is scheduled to be depleted of funds just as the pressure of the baby boomers retirement starts to be felt. Although the April 1999 report of the Social Security Trustees moved the date of depletion from 2010 to 2015, the new estimate is extremely fragile. The additional five years of Part A solvency are based on razor-thin surpluses over several years that could easily disappear if Part A expenditures increase slightly faster than anticipated or wage tax revenue grows slightly slower than anticipated. In addition, the pressure on general revenues from Part B growth will continue although this is less observable since Part B is not funded by a stand-alone trust fund.

However, the motivation for Medicare reform is and should be more than financial. Traditional Medicare is modeled after the indemnity insurance plans that dominated the way health care was organized and delivered in the 1960's. The benefit package also reflects the 1960's, not covering outpatient pharmaceuticals or protection against very large medical bills.

Because of the limited nature of the benefit package and, at least until recently, the restricted nature of plan choices allowed under Medicare, almost all seniors supplement traditional Medicare. The use of this two-tiered insurance strategy has had important consequences for both seniors and for the Medicare program. For many seniors, it has meant substantial additional costs, with annual premiums varying between $1000 and $3000 or more.

The supplemental plans have also meant additional costs for Medicare. By filling in the cost-sharing requirements of Medicare, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in the greater use of Medicare-covered services and thus increased Medicare costs.

In addition to concerns about the incentives associated with Medicare, there are also issues of equity. The amount Medicare spends on seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health status among seniors. Since seniors and others pay into the program on the basis of income or wages and pay the same premium for Part B services, this results in substantial cross-subsidies from people living in low cost states and states with conservative practice styles to people living in higher cost states and states with aggressive practice styles.

THE DIRECTION OF REFORM

I believe a program modeled after the Federal Employees Health Benefits Program or what is now generically referred to as a premium-support program would provide a better structure for Medicare. Such a program could produce a more financially stable and viable program, and would provide better incentives for seniors to choose efficient plans and/or providers and better financial incentives for physicians and other health care providers to produce high-quality, low-cost care. This type of program would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program, for the plan that suited their needs.

I am well aware that the premium support model remains controversial among some Members of Congress. However, I think it is important that committee members understand that many of the most vexing issues that need to be resolved for a premium support program must also be resolved for the current Medicare program. This will be true as long as the Medicare program includes a traditional fee-for-service benefit and a variety of Medicare replacement programs. These issues include risk adjustment, providing understandable and user-friendly information to seniors, assuring that quality care is being delivered and providing safeguards for frail and vulnerable populations.

Some are raising questions about the difficulties surrounding the Medicare+ Choice program and what that portends for premium support. Although the

Medicare+Choice program continues to grow, the growth rate has slowed down dramatically.

Understanding the problems being experienced by Medicare+Choice may help to prevent them from occurring in a premium support program. In some cases, plans just made bad business decisions. They went into too many markets or tried to enter markets where they were unable to form networks. Plans also found special problems entering rural areas, especially those with a single hospital or a few dominant provider groups. Finding ways to make more plan choices available in rural areas will clearly need more effort.

But other problems reflect actions by the government that can and should be addressed. There is substantial uncertainty about the "rules of the road" —new regulations and requirements, reimbursement changes, changing models of risk adjustment, etc. Equally disturbing is the growing differential in spending rates for Medicare services in traditional Medicare versus spending in Medicare replacement plans. These are issues that need to be resolved for Medicare+Choice as well as a premium-support model.

GETTING FROM "HERE" TO "THERE"

Historically, changes in Medicare reimbursement policy and structure have been phased in over several years. This has helped to cushion the disruption that abrupt changes could cause. It also makes sense to consider phasing-in changes in the structure or organization of a reformed Medicare program that requires substantially different roles for government or substantially different roles for the administrative institutions supporting the program such as exists with premium support. Any interest in experimenting with various strategies for reform or the administrative structures supporting reform makes it even more urgent that we begin the process now.

Concerns have been raised about instituting significant changes in a program involving the elderly. Many of today's seniors have had little experience with health plans other than fee-for-service indemnity plans, many seniors have modest incomes and some have little education. Whatever changes are made to the Medicare program may need to be modified for at least some subsets of the existing senior population. Some groups of seniors may be need to be excluded from any change.

Because of the difficulties that comes with changing programs involving seniors, it is important that we establish now where we want to go with a reformed Medicare program.

It is also important to understand that the people who will be reaching age 65 over the next decade as well as the baby-boomers have had very different experiences relative to today's seniors. Most of them have had health plans involving some forms of managed care, many of them have had at least some experience choosing among health plans, most have had more education than their parents and many will have more income and assets. The biggest change involves the women who will be turning 65. Most of these women will have had substantial periods in the labor force, many will have had direct experience with employer-sponsored insurance and at least some will have their own pensions and income as they reach retirement age. This means we need to think about tomorrow's seniors as a different generation, with different experiences, with potentially different health problems, and if we start soon, with different expectations.

THE ADMINISTRATIVE STRUCTURE SUPPORTING A REFORMED MEDICARE

At least two major administrative issues need to be addressed. The first involves using a Medicare Board as the major administrative structure supporting a premium support type of program. The second involves the potential role of the Health Care Financing Administration in running a modernized fee-for-service Medicare program.

I support the notion of a separate Medicare Board that would oversee and negotiate with the private plans and the traditional Medicare program. The most important functions of such a Medicare Board would be to review and approve benefit packages, to negotiate premiums, make payment modifications (such as risk adjustment), direct open enrollment periods and to provide information about plan choices.

While I think it is appropriate and proper that the individuals who have been involved in administering the Medicare+Choice program at HCFA be moved to the Board, it would be better to have a Board that is separate from HCFA and with leadership from outside of HCFA. It would be desirable to include people with experience administering the FEHB program, the CalPERS program and some of the more comparable programs from the private sector.

The reason I think a separate Medicare Board is desirable is that the mind-set of HCFA is focused on running a publicly administered, price-setting, fee-for-service system. The functions and roles for government in running and monitoring a premium support system are so fundamentally different from the experiences and mind-set of HCFA personnel that it would detract from rather than enhance the successful operations of a premium-support program.

The more difficult issue is whether HCFA or any governmental entity could administer a modernized fee-for-service system that competes effectively with privately administered plans. A series of changes would be needed to modernize the traditional Medicare program. These include the use of selective contracting, centers of excellence, disease management programs, best practice programs, variations in benefit structures and other changes that are commonplace in the better-run private sector plans.

The question in my mind is whether the Congress will allow HCFA the flexibility that would be needed to run such a program and whether the Congress and the Administration will provide HCFA with the resources needed to carry out such a task. History is not encouraging on either of these issues.

If HCFA or any other governmental agency is to run a modernized fee-for-service program, Congress will need to change its relationship with HCFA and retreat from its very micro-prescriptive directives. This would require both changes in statute and changes in attitude. It would also require changes in attitude and behavior by the employees of HCFA. Demonstration and/or adoption of promising ideas from the private sector have been painfully slow to be undertaken by HCFA. Some of this slowness may be caused by political difficulties associated with these strategies, such as the selective exclusion of providers, or by a lack of appropriate funding. But too often it appears to be the results of bureaucratic inaction and indecision.

An alternative to a publicly-administered, modernized fee-for-service Medicare program is the use of competitively-procured, private fee-for-service plans. These plans could be bid out on a risk basis at a national, regional or state level with plans using administered pricing if they chose to do so.

The attraction of the privately administered fee-for-service plans is that they can introduce changes in local markets that HCFA may not be able to do. But for many people, this is also the fundamental drawback of the privately administered plans. The public oversight and control of a publicly administered plan provides a sense of protection that will be difficult to ignore and at least to me, the political objections likely to result from eliminating a publicly administered traditional Medicare program, seem overwhelming.

This means that if there is to be a publicly-administered, modernized fee-for-service component to a premium support program, which I think is both desirable and politically necessary, Congress will need to change its relationship with HCFA and grant it more flexibility than it has done in the past. In return, HCFA will need to be more responsive, more pragmatic and more creative in its behavior.

Chairman THOMAS. Thank you very much, Dr. Wilensky.

Dr. Dowd.

STATEMENT OF BRYAN DOWD, PH.D., PROFESSOR, DIVISION OF HEALTH SERVICES RESEARCH AND POLICY, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MINNESOTA

Dr. DOWD. Thank you, Mr. Chairman and Subcommittee Members, and thank you for the opportunity to appear here today.

I am a professor at the University of Minnesota. My colleagues and I have spent the last 20 years analyzing health insurance purchasing strategies and ways to apply the most successful of those strategies to the Medicare Program. Our research is non-partisan. It has been sponsored by HCFA, the American Enterprise Institute, the Robert Wood Johnson Foundation, and the National Academy for Social Insurance. Currently, we are providing technical assistance to HCFA on the congressionally-mandated competitive pricing

demonstration project. Despite these various affiliations, I want to be clear that the opinions that I express today are purely my own.

Under the current payment system for Medicare+Choice plans, the Government tells health plans how much it will pay them to care for Medicare beneficiaries. In other words, information about the cost of caring for beneficiaries flows from the organization that knows the least about the health plan's true cost, that is, the Government, toward the organization that knows the most about the true cost of care, that is, the health plan. That to use seems perverse. Instead, we think health plans should be telling the Government how much it costs to care for Medicare beneficiaries.

Our proposal for competitive pricing in the Medicare Program, which is virtually identical to the system used by the State of Minnesota, would offer fee-for-service Medicare to all beneficiaries, regardless of their location, and would contract with HMOs in market areas where HMOs are available.

The government would pay the full cost of the low-cost health plan and beneficiaries would pay the cost of more expensive plans out of their pocket. That is how I get my health insurance and how I have gotten it for the last 15 years.

Now, apparently, we are not alone in our admiration of purchasing systems that are used by large employers. Virtually every Medicare reform proposal being discussed today, from the Clinton administration proposal to that of the Heritage Foundation, contains some element of competitive pricing. Most importantly, in 1997, Congress mandated HCFA to conduct a demonstration of competitive pricing for Medicare in at least four sites. Congress established the Competitive Pricing Advisory Committee, or CPAC, to design the demonstration and pick the sites.

Now, CPAC members include former Senator Dave Durenberger, Bob Reischauer, John Rother, Chip Kahn, and other national experts. CPAC subjected 30 different design parameters and over 300 potential demonstration sites to expert analysis and open public debate. Their final design was not our proposal, nor was it the Breaux-Thomas proposal, the Clinton proposal, or HCFA's proposal. It was a negotiated compromise hammered out by people who were face to face with the reality of putting a demonstration project on the ground in short order.

CPAC also selected two initial demonstration sites: Kansas City and Phoenix. The result, as you probably know, is that legislation to kill the demonstration in these two sites already has been passed by the Senate as a rider to their Patient Protection Act. If this legislation comes before you, I would implore you to consider your decision carefully.

I know there is discussion about establishing an independent board to run various aspects of the Medicare Program, but I suggest to you that Congress has already established an independent board of national experts to run what is perhaps the most important demonstration project in the history of the Medicare Program. The question before Congress at this point is whether that independent board will be allowed to complete the tasks that it was assigned by Congress.

I want to finish my testimony today by addressing one of the most controversial points in the Medicare competitive pricing de-

bate, that is, the degree to which fee-for-service Medicare should be included in a competitive pricing system.

Now, there are good arguments in favor of including fee-for-service Medicare. That system is most likely to produce the best bids from health plans. We found that employers who adopt a defined contribution system for all of their health plans have total health insurance costs, that is, the part paid by both employers and employees, that are about 7 percent lower on average than employers who subsidize the cost of high-priced health plans.

However, there are also good arguments in favor of providing some subsidy for the consumer's cost of high-cost plans. The main empirical argument, despite our advice to the contrary, is that most employers do it. The Federal Employees Health Benefit Plan is a good example, with its level percentage contribution up to a cap. About two-thirds of the employers in our survey data subsidize high-cost plans to some degree.

Another consideration, for better or worse, is that the fee-for-service Medicare sector operates under a different set of rules than private sector plans, and those differences either must be addressed or accommodated in any competitive pricing system that includes the fee-for-service sector. I think that what I have seen of the Breaux-Thomas proposal is very clear on that point.

Federal and State governments also subsidize the cost of higher-priced health plans through the tax exemption of health insurance premiums which provide an equal percentage subsidy of higher-cost plans for any given consumer.

It is our hope, in the interest of addressing the fundamental problems of information flows, inefficiency, and inequity in the current Medicare Program, that some compromise can be reached on inclusion of fee-for-service and the appropriate level of subsidy for high-priced health plans.

That concludes my remarks. I will be happy to provide copies of our studies to anyone who would like them, and I look forward to your questions. Thank you.

[The prepared statement follows:]

Statement of Bryan Dowd, Ph.D., Professor, Division of Health Services Research and Policy, School of Public Health, University of Minnesota

OUTLINE

I. Two objectives of Medicare contracts with private health plans:
A. Offer Medicare beneficiaries the same choices that are available through employment-based insurance.
B. Create price-based competition to improve quality and reduce cost
II. The primary problem with the current payment system for Medicare+Choice plans:
A. Information about cost flows from the government to the health plans
B. Competitive pricing reverses that information flow
III. Large employers provide an interesting model
A. They offer multiple health plans during open enrollment periods with good consumer information
B. They often offer their own self-insured FFS plan, in addition to HMOs that are available in each market area.
C. Premium contribution methods vary widely.
IV. Growing consensus on bidding models
A. Our proposal, Breaux-Thomas, the FEHBP proposals and even President Clinton's plan include some type of bidding.
B. Congress mandated a demonstration of bidding for M+C plans as part of 1997 BBA

V. The Congressionally-Mandated Demonstration of Competitive Pricing
A. Established an independent national expert advisory panel (The Competitive Pricing Advisory Committee or CPAC)
B. Told CPAC to design the demonstration and choose the sites.
C. CPAC complete its tasks.
D. Congressionally-mandated Area Advisory Commissions (AACs) were formed and provided input.
E. Congress is threatening to kill the Demonstration.
VI. Should traditional FFS Medicare be included in the bidding system?
A. Arguments in favor of including FFS Medicare:
1. Fairness (level playing field with private plans)
2. Defined contribution for all plans reduces costs.
B. Arguments in favor of subsidizing the consumer's cost of high-priced health plans:
1. Most employers do it.
2. May help compensate plans that attract high cost enrollees.
3. Consumers may like being protected from having to pay the full premium differential of the high-cost plan, should they ever want to join it.

REMARKS TO THE HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE

Mr. Chairman and Committee members, thank you for the opportunity to appear before this Committee. I and Roger Feldman, my colleague at the University of Minnesota, have spent the last twenty years working on analyses of private sector health insurance purchasing strategies, and thinking about ways to apply the most successful of those strategies to the Medicare program. Our work is non-partisan. We have completed several design projects for HCFA, written a book on the subject that was published by the American Enterprise Institute, and contributed to a book on Medicare reform edited by the National Academy of Social Insurance. For the past four years, along with Abt Associates, we have provided technical assistance to HCFA on the Competitive Pricing Demonstration project.

When we first took up the question of how to pay Medicare HMOs in 1989 we started by asking two basic questions: what are the goals of contracting with private health plans in the Medicare program; and what sort of payment system would advance those goals?

The goals are two-fold:

(1) to offer Medicare beneficiaries the same health plan choices that are available through employment-based health insurance, and

(2) to create price-based competition among health plans that can help improve quality and reduce cost.

Unfortunately, the government's method of contracting with private health plans does not meet those goals. In the 1980s, despite some sound advice to the contrary, Congress set up an administrative pricing system to pay Medicare HMOs. Under that system, the government tells health plans how much it will pay them to care for Medicare beneficiaries. Prior to the Balanced Budget Act of 1997 (BBA), the government told health plans they would be paid 95 percent of the estimated cost of caring for "similar" beneficiaries in the FFS sector. Post-BBA, the government tells health plans they will be paid an amount based on the old payment system, adjusted by a schedule of fixed percentage increases. In both systems, the information about the cost of caring for beneficiaries flows from the organization that knows the least about true costs, i.e., the government, to the organization that knows the most about the true cost of care, i.e., the health plan. That strikes us as perverse.

A number of prominent analyses of the HMO payment system have defined that problem with the current system as the government not being very good at guessing the health plans' true cost. They have proposed a multitude of ways to help the government guess better, primarily by including more variables in the government's payment formula for HMOs.

Our analysis of the problem in 1989 was quite different. We thought that the primary problem was not that the government was guessing badly, but that the government was guessing at all. We proposed that the flow of information should be reversed. In other words, the health plans should be telling the government how much it cost to care for Medicare beneficiaries, not the other way around. Ten years later, that simple idea still makes sense to us.

We began to look for a model of how to reverse the flow of information, and of course, we didn't have to look far, because virtually all major purchasers of health insurance except the federal government, ask health plans to submit bids. Of course, when you ask health plans to reveal their cost through the bidding process, you need to give them some incentive to tell you the truth, and that market discipline

generally is provided by the threat of not being offered, or having consumers face a higher out-of-pocket premium.

In our own proposal for competitive pricing, we suggested that rather than throwing health plans out of the Medicare program, the government simply should set its contribution to premiums at the lowest bid submitted by a qualified health plan in each market area, so that consumers pay the marginal cost of more expensive plans out of their own pocket. That is the same system under which I get my health insurance through the State of Minnesota, and over the past ten years it has produced very low premium increase including some years in which premiums actually declined. In fact, our entire proposal was modelled in the success of large employers that offer multiple health plans to their employees. Many of those employers, like Medicare, also offer a self-insured fee-for-service plan that is available to all consumers in all locations. Again, that is exactly the model used by my employer.

Our proposal combined a defined benefit with a defined contribution. The government's premium contribution was limited to the lowest priced plan, but unlike some voucher proposals, beneficiaries were guaranteed that they could purchase the benefits to which they were entitled for no more than the Part B premium. In our proposal, FFS Medicare was included as a bidding health plan, as in the Breaux-Thomas proposal.

Apparently we were not alone in our admiration of the purchasing systems of large employers. Virtually every Medicare reform proposal being discussed today contains some version of competitive pricing. In fact, competitive pricing is one of the few common elements among the major reform proposals.

Most importantly, in 1997, Congress agreed that competitive pricing should have a fair test in the marketplace. Congress mandated HCFA to conduct a demonstration of competitive pricing in at least four sites. Congress also established the Competitive Pricing Advisory Committee or "CPAC" with representation from consumers, health plans, providers, employers and policymakers. Congress charged CPAC with designing the demonstration and choosing the demonstration sites. CPAC members include former Senator Dave Durenberger, Bob Reischauer, John Rother, Chip Kahn, and other national experts. CPAC carried out its duties carefully and expeditiously. They subjected 30 different design decisions and 300 potential sites to expert analysis and open public debate. Their final design was not our proposal. Nor was it the Breaux-Thomas proposal, the Clinton proposal, HCFA's proposal, the FEHBP proposal or the Heritage Foundation's proposal. It did, however contain the common element in all those proposals: health plans submit bids, rather than being told by the government how much they will be paid.

CPAC also selected two initial demonstration sites: Kansas City and Phoenix. The Congressionally-mandated Area Advisory Committees or AACs were established in each demonstration site, again consisting of representatives of consumers, health plans, providers, employers and policymakers. The Kansas City AAC met for the first time on March 22, of this year, under the direction of Edward Holland, Assistant Vice-President for Corporate Benefits at Sprint Corporation. By May 12, the Kansas City AAC had completed all the tasks assigned to it by CPAC.[1] The Phoenix AAC was not as successful in completing its tasks, but had made substantial progress by July of this year.

So what we have here is a Congressionally-mandated demonstration project, designed by a Congressionally-mandated, independent task force of national experts, implemented in sites chosen by that independent task force, and advised at the local level by the Congressionally-mandated, independent Area Advisory Committees. Only the most cynical among you will not be surprised when I tell you that the greatest current threat to this Congressionally-mandated demonstration is Congress itself. In fact, legislation to kill the demonstration in Kansas City and Phoenix already has been passed by the Senate as a rider to their Patient Protection Act (Senate Bill 1344).

Recently, the Co-Chairs of CPAC, Bob Berenson of HCFA and James Cubbin, Executive Director of Health Care Initiatives for General Motors, wrote to Chairman Thomas saying, and I quote:

> The Balanced Budget Act gave CPAC the sole authority to select sites for this demonstration. If Congress decides to override CPAC's decision on sites and take action to exempt Kansas City and Phoenix as demonstration sites, in our

[1] The four tasks delegated to the AACs by the CPAC were (1) specifying the "market norm" standard benefit package in each site, (2) choosing the median or weighted average bid as the government contribution rule, (3) exercising an option to delay the new PIP-DCG risk adjustment system in the first year of the demonstration, and (4) deciding whether plans should submit separate bids on each county in the demonstration area, or bid on a "reference" county with payments to other counties determined by payment ratios under the current system.

judgement, CPAC would not be able to carry out its mission as specified in BBA 97.

If this legislation comes before you, I would implore you to consider your decision carefully. I left a meeting of CPAC at noon today to come to this hearing. The message I would like to take back to CPAC at 3:30 this afternoon is that the members of this Subcommittee place a high value on the hundreds of hours that these national health care leaders have devoted to the tasks that Congress assigned them, and that you intend to be a reliable partner with them in Medicare reform efforts, not a group that mandates demonstrations one day and kills them the next.

I would like to finish my testimony today by addressing one of the most controversial points in the Medicare competitive pricing debate: the degree to which traditional FFS Medicare should be included in the competitive pricing system. There are good arguments in favor of including FFS Medicare in a defined contribution system. Such a system is viewed as fair by the private health plans that must compete against the government-sponsored FFS plan. Furthermore, a defined contribution that applies to all health plans is likely to produce the best prices from health plans. In a recent study of large employers, we found that employers who adopt a defined contribution have total health insurance costs (including the portion of the premium paid by both employers and employees) that are about seven percent lower, on average, than employers who subsidize the cost of high-priced health plans.

However, there also are good arguments in favor of subsidizing the consumer's cost of higher-priced health plans. The main empirical argument favoring that approach is that most employers do it. Only about one-third of the employers in our sample set a defined contribution to premiums. The Federal Employees Health Benefit Plan (FEHBP) is an example of a large employer that does not set a defined contribution to premiums. FEHBP sets a level percentage contribution to premiums, up to a cap, thus subsidizing the consumer's cost of higher-priced plans.

Why would employers reject a defined contribution system that has been shown to save money? There are several possible answers. Subsidizing high cost plans may be one way to compensate plans that attract higher cost enrollees. Also, consumers currently in low cost plans may like knowing that if they ever wanted to join the high cost plan, the premium would be subsidized, to some degree. We don't know all the reasons why employers subsidize the consumer's cost of higher-priced health plans, but it appears to be common practice. Federal and state governments also subsidize the cost of higher-priced health plans, through the tax exemption of health insurance premiums, which provides an equal percentage subsidy of higher cost plans for any given consumer. It seems to us that a some compromise on the inclusion of FFS, and the appropriate level of subsidy, could be reached.

I will conclude my remarks at this time. I will be happy to provide copies of our studies to anyone who would like them, and I look forward to your questions.

Chairman THOMAS. Thank you, Doctor.

Mr. Walker, one of the things that the Medicare Commission looked at what the concern that historically part of the driving force for change on Medicare was the "insolvency" of Medicare. And when we tried to look at a model—and Social Security came to mind—it was fairly obvious that applying a dedicated tax model from Social Security, which has 100 percent of its funds in that model and then when it has no money there, it truly is insolvent, versus a plan that is partially paid out of a general fund and, in fact, based upon recent decisions in BBA 1997 and the President's ongoing proposal, one of the easiest ways to solve the insolvency of Medicare is to continue to transfer either programmatically to the general fund or simply dollars over to the HI Trust Fund.

We tried to focus on the sources of money, the dedicated payroll taxes, the general fund, and the beneficiaries. One of the difficulties in getting a good dialog going about what the problem is is that the general fund portion is an entitlement, and it really does stay below the surface in any kind of a discussion.

We came to the conclusion that, in essence, forcing a public discussion about the relative share of the costs of the Medicare Program between those funding sources and the need for more money carried on as a general debate before you could transfer funds from the general fund or increase beneficiaries or increase payroll taxes, was in part inhibited because of the way we define solvency and insolvency today. So we came up with a different way of doing it called programmatic insolvency.

Did you look at that portion of the——

Mr. WALKER. I am somewhat familiar with it, yes.

Chairman THOMAS. Is that a useful concept. Does it help us at least elevate it to a public discussion of the relative share of moneys?

Mr. WALKER. I think solvency is too limited. I think solvency can be misleading. It is not that it is unimportant, but the fact of the matter is that the assets that are in the trust fund right now represent Government securities. Basically what they represent is a first claim on future general revenues. That is what they are.

I think if you are going to move to a shared financing source, partially dedicated payroll taxes, partially premiums, partially general revenues. I think it is important to look beyond solvency, to look at such things as percentage of the economy, percentage of the budget, to look at other factors. Because one of the concerns that we have, Mr. Chairman and Members of the Committee is we need to also look at sustainability. Can we keep the promises that have been made? And looking at it from the standpoint of percentage of the budget and percentage of the economy, is frankly a lot more relevant in making those judgments than solvency.

Chairman THOMAS. And, in fact, that is what the Commission did. It took an arbitrary figure of 40 percent of the General Fund exposure and used that as a programmatic insolvency criteria, which would trigger the discussion of where and how the finances would come from.

Mr. WALKER. Mr. Chairman, I think one of the basic problems we have in health care, which is not just Medicare, it's much broader, is a fundamental disconnect between who gets and who pays, a fundamental disconnect on behalf of individuals, not the Government, not employers, not providers, but individuals on cost and quality of care. They do not have adequate transparency, they do not have adequate incentives. Whether it be through Medicare or whether it be through, frankly, the tax system, that is the fundamental problem.

Chairman THOMAS. Well, I would even go one step further. We don't have a very educated consumer in this area, with woefully inadequate information available to make a decision, even if you wanted to be an educated consumer. That is why confidentiality, the collection of data, the ability to put outcomes and all of that is part of the solution to the problem.

Dr. Moon, I want to thank you in recent publications where you have taken the time in print to distinguish, at least in concept, defined contributions from a premium support versus voucher. It is true that if you mess up in a number of ways, they can all wind up looking the same. But that if you do understand that there is a difference, it allows you to at least see what we believe to be

some significant differences on the emphasis of the ability to share the cost of increases. I know others have not been as discriminating or as sophisticated, and I want to thank you for that.

But the question I want to ask you runs through I think all three of the other panelists. In terms of this business of fee-for-service being such a big chunk, and we know it is going to be a big chunk, and then the managed plans as an option, the difficulty I have is that today, in Medicare+Choice and in some models that have been discussed, is that the managed one, because of the way in which it is run, lends itself to a requirement of a cost-quality comparison. And the idea of a risk adjuster, as is contemplated by the administration, is within the managed area, with dollars being removed from a fixed amount.

But you have got an entitlement program over here that is not subjected to the same cost and quality criteria with an unlimited funding arrangement. And I guess I would tell you, Dr. Wilensky, that some of us would be more willing to give the management tools you talked about to HCFA if they would subject themselves to some of the cost and quality comparisons that we are utilizing in other areas. There are two sides to the ledger. Let them go out and be "competitive." But the downside of that, of course, is that you also have to be measured by the same measurements that are used elsewhere.

Any reactions from anybody?

Ms. MOON. I would like to indicate that I think that one of the things that you are talking about, in terms of holding fee-for-service accountable I think is very important. We need to work very hard on finding new tools and new ways to deal with a part of the Medicare Program that is going to be around for a long time.

Chairman THOMAS. But just let me interrupt, just briefly, because we do have what we call cost and quality comparisons, but they are surrogates for the real thing, which is what do you do in the real world on a direct relationship on a cost basis. And I would really like real world cost and quality comparisons rather than the surrogates that we now use.

Ms. MOON. OK. But I do think that whether you have the current system of Medicare+Choice or a premium support kind of model, you are going to have people comparing the private plans to the traditional Medicare Program. And so, to some extent, there is, I think already, that kind of a comparison that people can make. They do need some additional information and tools to be able to understand those tradeoffs. And I think that those tradeoffs are not very clear to individuals right now.

Ms. WILENSKY. I support the notion that we ought to have common requirements and common payment, common spending with regard to the risk plans or however we want to call these Medicare replacement or Medicare Choice plans and traditional Medicare.

As I indicated in my testimony, I am very concerned that the spending between traditional Medicare and the Choice plans or the risk plans is diverging at both ends of the scale. I think that is an invitation to difficulty. I think it is important that we have information on the quality and the outcomes. It needs to be available for traditional Medicare, as well as the Choice plan. I very much agree with the comments you made, that if the Congress is to grant

HCFA more flexibility, it ought to demand more accountability. It has not in the past. It is within your right to so demand.

We need to get these issues so that, frankly, the Government is not trying to push or pull people either out of or into various plans, but to give them information, to make adjustments for a health status that is critical and to make sure that plans are providing quality health care, and they are not cheating in any way in terms of their enrollment. That is a very important job that needs to be done.

Chairman THOMAS. And the long overdue education program ought not to be funded by one particular element of the program across the entire structure, which obviously was the——

Ms. WILENSKY. MedPAC has, as you know, already recommended that it is inappropriate to use only the risk plans to fund medical education. We think it is important that people know what they are choosing, but that is a broad Medicare function.

Chairman THOMAS. But that mental set is the key to the point you made about HCFA doing fairly well on an administered, bureaucratic fee-for-service structure, but doesn't understand the concept of managed care.

Does the gentleman wish to respond at all, Mr. Dowd?

Mr. DOWD. Yes. We have been fans for a long time of trying to level the playing field between HMOs and fee-for-service Medicare. That will cut both ways, though, as you suggest, and so that is important.

I also support the idea of very careful monitoring of what is going on in both fee-for-service Medicare and HMOs. To a certain extent, we are sort of running a competitive pricing demonstration now on the HMO side because, with the changes in the HMO payment that are put in place by BBA, we are lowering the payments on the high side relative to the true cost of care. We are raising them on the low side. In a sense, that is what we would call a Dutch auction. You keep raising the prices until something good happens or lowering them until something bad happens. And it is important to me that we have the monitoring systems in place so that we know when good things and bad things happen.

Chairman THOMAS. Thank you. My time is up, and I want to turn it over to the gentleman from California.

But to, Mr. Walker, I want to say thank you. In your written testimony, you made some very nice statements about some things that have been done and that you wanted Congress to hold the line on the Balanced Budget amendment changes that we made.

I want to assure you that if we decide to make any adjustments in the area, it is not because we have caved to any pressure about rolling back. We cannot roll back. But part of the deal was that prospective payment structures, going from the old Cost Plus to these new ones, were promised on a certain time table, and they haven't been delivered. And we put some plug numbers in there, and those plug numbers were not designed to be a 2- to 3-year period.

And in legislation, as broad-based as the BBA, you inevitably think you said one thing, and the lawyers are now telling you that you actually did something else. So the traditional term is a "trailer bill." There are some provisions for that. But I can assure you

that your concern, at least from the Chairman of this Subcommittee, is not that we intend to rollback BBA, in any way, but to fine-tune it in areas where we believe there is potentially a need.

So I appreciate your written comments.

Mr. WALKER. Mr. Chairman, obviously, some refinements may be necessary for a lot of the reasons that you articulated. But it is important to target those refinements, to base them on hard data. For example, some of the data for 1998 is just now becoming available.

And in addition, I think what this does is it serves as a precursor of how tough this is going to be going forward. I mean, the fact of the matter is everybody has unlimited wants here, whether it is the individuals, whether it is the providers, meaning the hospitals, the physicians or whatever. And ultimately I think we are going to have to ask ourselves a much more fundamental question than historically we have done. Rather than incrementally making changes to existing systems, we are going to have step back and say, OK. Where are we at? Where should we be going? What do people need versus what they want? And what is the best way to address that in a way that is affordable that we can deliver on the promise, not just today, but for future generations?

Chairman THOMAS. Appreciate that. We made our first run at it, got 10 out of 11 votes. We will do it again.

The gentleman from California?

Mr. STARK. Thank you, Mr. Chairman.

General Walker, I don't think I heard you deal with the part of your testimony on 12 and 13, pages 12 and 13, where, in effect, you say—or not in effect—but if I may quote you, You say, "Ironically, Medicare Managed Care cost, not saved, the Government money." And then you further go on that you have reported in a paper or a monograph that you reference in your footnote that "Factors additional to or exclusive of payment rates, including competition and market conditions, played a significant role in the 1999 plan dropouts."

Now, I suspect that what you are saying there was that if we were going to try and save some money with the Cost Plus Choice or whatever it is, we didn't. That is fair?

Mr. WALKER. Yes, Congressman Stark.

Basically, what happened was the failure to have a proper risk adjustment meant that caused this, in part.

Mr. STARK. Well, and now we find that all Medicare HMOs offering drug coverage will charge copayments for that next year, which was not the case in a large number. So that these experiments, I guess my only quarrel, coming from an area that has been served by Kaiser, and there are other excellent areas of the country, that we are just pushing it too fast; that the HMO's biggest worry is one of two, they will have too many patients or too few. And anything below or above causes them real problems. And by our trying to force-feed whatever might happen, we do create some problems.

Second, I wanted to just point out that the premium support, as I read it, is an attempt to end Medicare as an entitlement. This 40-percent draw, on page 8 of the March 15 description, says that "If the draw is exceeded by 40 percent . . ." that means that more than 40 percent of the program comes out of general revenues ". . .

it would require congressional approval to authorize any additional contributions."

Now, General, isn't that correct that if that's what it says, if you did that, that ends it as an entitlement and turns it into a defined contribution, wherein the Government will contribute no more than 40 percent of the aggregate from general revenues? Am I saying that——

Mr. WALKER. Basically, what it does is provide a mechanism which would, as I understand it, force Congress to go back and make a conscious decision——

Mr. STARK. To appropriate the money.

Mr. WALKER. Correct. To make a conscious decision whether or not to violate the limit.

Mr. STARK. Then it ain't an entitlement any more. And the third or last thing that I would——

Chairman THOMAS. Would the gentleman yield just briefly?

Mr. STARK. Sure.

Chairman THOMAS. That would be one of the choices available. They could just as easily raise the HI taxes or to increase beneficiaries' amount——

Mr. STARK. But they have to act. Now they don't. Now it's an entitlement, and I get my Medicare benefits regardless of what we do here. And so, by definition, Medicare would cease to be an entitlement.

Now, I have heard an awful lot about people purchasing medical care, and I contend, have always contended it is impossible for the layman, even those of us in this room who are perhaps more familiar with medical provider options than others, but I just would suggest this. One of our interns of the Joint Economic Committee spent a couple of weeks, and she dreamed up this question for health care providers in the Washington, D.C., area. Her father, she said, was 63 and had no health insurance and was having a severe attack of kidney stones, but had a lot of money or she was willing to pay for lithotripsy to help pop. How much would it cost?

Well, it took her 2 weeks to get answers. Now, if any of you have had any experience with kidney stones, 2 weeks is beyond the millennium. Well, it is interesting that in the area here, in the Washington, D.C., area, out of eight providers who—some wouldn't answer at all. They just wouldn't tell her what it cost or wouldn't call back—Johns Hopkins won with $5,300 for the hospital and the doc, and UVA in Charlottesville somewhere they said between $8- and $10,000.

So let's take $9,000, almost a $4 thousand difference here for the same procedure if you get down and you can possibly drag that information out of these providers who don't really choose to tell you. And some, in the initial calls, just said, "Well, we don't give that information out."

Well, my question is I am not sure that it is the Government and the payers. I am not sure the providers, quite frankly, want to tell us what it costs, particularly until they see how much money we have got, and then I will bet you the cost tends to come amazingly close to whatever they think we can pay.

So I have always said that I don't think the market can work because there is no good basis for any of us getting the information. And without reasonable information, markets can't exist.

So, Mr. Chairman, I hope we don't have entitlements. I hope we don't have premium support. I hope we slow down the growth of for-profit managed care plans, which they may all go broke, and that would probably be the best thing we could do for Medicare beneficiaries.

Thanks again for the hearing.

Mr. WALKER. Mr. Chairman, may I comment?

Chairman THOMAS. Sure.

Mr. WALKER. I think one of the things, with all due respect, Congressman, I think that the Congress really needs to consider, given these charts, because these are based upon trusty intermediate assumptions for Social Security and Medicare, they are based upon CBO estimates, economic assumptions, which are not that different from OMB. And basically what they say is the debate needs to be also what percentage of our economy and what percentage of our budget do we want to dedicate to health care.

And you are right, Congressman, that managed competition is not a panacea, by any means, as we have heard. But I think we have to ask ourselves some of those fundamental questions and figure out how to get there.

Chairman THOMAS. The gentleman's time has expired. We have got less than 5 minutes to vote. And just briefly, the gentleman from Louisiana.

Mr. MCCRERY. I have a quick question for any of the panelists. I don't know the answer to this, but I am curious. It goes along the lines of the entitlement question that Mr. Stark posed.

If the HI Trust Fund runs out of money, if we don't have sufficient money—or let me put it another way—if we don't have sufficient money in the trust fund to pay all of the bills, does current law authorize us to simply make up the difference with general revenues?

Mr. WALKER. That is a legal question. My understanding is, that you can only use the trust fund assets to pay for benefits. But if the trust fund runs out of assets, then I would ask the trustee what happens.

Ms. MOON. I think the legislation is not clear on that point. And I know that that had come up at some point.

Chairman THOMAS. We are down to 3 minutes, and we are getting pressed again. And the point is entitlements would end in that situation as well.

Mr. MCCRERY. Yes. I mean, we may not have an entitlement in the ideal that Mr. Stark posed it.

Chairman THOMAS. Exactly.

Mr. MCCRERY. So if we run bone dry in the trust fund, it may, in fact, require congressional action, just as it would under the Commission's proposal.

Chairman THOMAS. Does the gentlewoman from Connecticut wish to make a——

Mrs. JOHNSON. I just want to make a comment. I appreciate the quality of your testimony and the degree to which this hearing has focused on the seriousness of the problems in Medicare and their

significance to the whole country long term. But I wish you would, and I also appreciate, Dr. Dowd, your pointing out to us what happened in the Senate Patient Bill of Rights. I will, at least, certainly support knocking out that provision. I think it is outrageous to set up a demonstration project and then not have the courage to stand by it.

But I would appreciate it if you would try to focus on what are the two concrete actions we should take this session to secure Medicare in the future? Because we have got to start acting now. Clearly, we can't get a macro solution. And so, if you would get back to me in writing with the two things you think it would be wisest for us to accomplish in this year's legislation, I would appreciate it.

Chairman THOMAS. Thank the gentlewoman.

The Subcommittee is adjourned.

[Whereupon, at 4 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Douglas R. Wilwerding, Chief Executive Officer, Omnium Worldwide, Omaha, NE, and Accent Insurance Recovery Solutions, Omoha, NE

The administration of the Medicare program greatly rests on the shoulders of its contractors who are responsible for: (1) receiving claims; (2) judging their appropriateness; (3) paying appropriate claims promptly; (4) identifying potentially fraudulent claims or providers, and withholding payment if necessary; and (5) recovering overpayments or inappropriate payments. When Medicare contractors do not perform these functions correctly or appropriately, the Medicare program loses billions of dollars. The actions of Medicare contractors, therefore, greatly impact the future of the Medicare program.

As reported in the September 20th New York Times—as well as in recent reports by the General Accounting Office—contractors are not performing the most basic claim paying functions, and are, in fact, defrauding the Medicare program. If contractors are not acting in a manner to stop the flow of inappropriate dollars from the Medicare program, and are in fact acting in a manner that promotes the inappropriate flow of dollars, then the Health Care Financing Administration should implement resources from the private sector to halt the waste of taxpayer money.

I can speak specifically for the fifth function named above: overpayment identification and recovery. Medicare contractors make overpayments during the normal course of business. An overpayment is excess money released on a claim, in total or in part, paid to a provider of service or a beneficiary. Medicare contractors make billions of dollars of overpayments every year. However, they are not doing enough to identify overpaid claims nor are they doing enough to pursue recovery from the overpaid party.

The private health insurance industry also makes billions of dollars in overpayments a year. But, the private sector realizes the value of retrieving this overpaid money. Private insurance companies employ specialized recovery firms to identify and pursue overpaid funds, resulting in millions of dollars returned back to the health insurance plan, helping to keep health care premiums down. The same successful procedures could be used to return billions to the Medicare program, funds that could be used to extend the life of the program, or provide additional benefits such as pharmaceutical coverage.

The concept of private recovery firms working on Medicare claims has been recognized and contemplated by other Congressional committees. H.R. 1827, introduced by the Government Reform Committee, would mandate the identification and recovery of overpayments, paying particular attention to the Medicare program by singling it out for a demonstration project testing the abilities of private recovery firms. In addition, the Senate Appropriations bill is recommending the Department of Health and Human Services' Inspector General's office to perform a study on the use of private recovery firms on Medicare overpayments.

Under the Health Insurance Portability and Accountability Act, HCFA has complete authority to contract with eligible entities for the recovery of payments that should not have been made. HIPAA also gives HCFA the funding to enter such contracts. HCFA has been slow to implement any such program despite its vast re-

sources. Instead they continue to rely on their contractors for overpayment identification and recovery. However, as the reported in the New York Times and by the GAO, contractors are not even performing the most important functions of paying claims or answering phones. It can therefore be reasonably assumed they aren't adequately performing identification and recovery of overpayment, which is a process that is usually overlooked because it doesn't impact the daily functions of paying claims.

I look forward to discussing with the Committee the services the private sector can offer the Medicare program and how such private sector services could easily be tested with Medicare contractors. Thank you for the opportunity to submit this written testimony.

Statement of Karen S. Fennell, RN, MS, Senior Policy Analyst, American College of Nurse-Midwives

The American College of Nurse-Midwives (ACNM) believes that the Medicare program would be strengthened by expanding access for disabled women to preventive health services and maternity care services provided by Certified Nurse-Midwives (CNMs) and free-standing birth centers.

The ACNM makes the following recommendations:

• Medicare reimbursement for CNM services should be increased from 65 percent of the physician fee schedule to 95 percent of the physician fee schedule.

• Medicare should establish a global payment for accredited free-standing birth centers.

These recommendations are included in The Certified Nurse-Midwives Medicare Services Act of 1999 (HR 2817). We urge the Committee to approve this important legislation.

The American College of Nurse-Midwives (ACNM), the national professional organization for certified nurse-midwives (CNMs), welcomes the opportunity to submit testimony before the Health Subcommittee on Strengthening Medicare by ensuring enrollees' access to benefits and by improving their choice of plans and providers.

A. THE PROFESSIONAL PRACTICE OF CNMS

A certified nurse-midwife is a registered nurse with advanced, formal education in midwifery who cares for women throughout the life cycle. Nurse-midwifery practice is the independent management of women's primary health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women. The certified nurse-midwife practices within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client.

In 1996, nurse-midwives attended over 239,000 births in hospitals, free-standing birth centers and homes, and provided over five million visits to women and newborns. Fifty-six percent of women who are cared for by CNMs live in areas that are designated as underserved, within inner city or rural areas. In fact, 70 percent of women and newborns seen by nurse-midwives are considered vulnerable by virtue of age, socioeconomic status, education, ethnicity, or place of residence. In addition, CNMs have a long history of working collaboratively with physicians and other health care providers to assure that quality, individualized care is available to high risk mothers, newborns and the disabled. Over 200 certified nurse-midwives serve as faculty of medical schools, teaching and supervising residents.

B. PROVISION OF PRIMARY CARE

As is documented in many research publications, nurse-midwives have a long history of providing first contact, comprehensive care with a focus on health promotion and disease prevention.

The ACNM is committed to ensuring that disabled women and their families do not get short-changed in the primary care movement. We are concerned about models of "primary care" that: do not provide continuity of care to disabled women, do not allow for choice of different types of providers, decrease access to individualized care, and lose the voice of women in determining what is appropriate for themselves and their families. For example, studies have documented that chronically disabled women who have specialists as their primary care providers are sometimes neglected with regard to their obstetrical and gynecological needs. Often, too little time and resources are allocated to nutrition counseling, STD screening and education,

family planning services, risk reduction counseling, as well as mental health evaluation and treatment. The recent Medicare Managed Care demonstration projects totally left out disabled women of childbearing years. However, in 1996 there were approximately 5,200,000 women under 65 years of age enrolled in Medicare through the disabled program. The Medicare statistical files for 1996, the most recent available data from HCFA, indicate that in the MCH 14 grouping over 50,000 women were cared for in hospitals with a primary diagnosis related to "pregnancy, childbirth and puerperium."

C. The Medicare Population and Accessability to CNMs and Free-standing Birth Centers

The ACNM is committed to increasing Medicare beneficiaries' access to midwifery care. Medicare payment policies have made it almost impossible for CNMs to serve this population. Medicare has provided for coverage of the professional services of CNMs since July 1, 1988. The law provided the Secretary of Health and Human Services with very little guidance as to how the fee schedule should be established, except to stipulate that payment for the CNM service cannot be greater than 65 percent of the applicable prevailing charge for the same services when performed by a physician.

This low level of payment results in CNMs being paid $800–1,200 for nine to ten months of care for pregnancy, including deliveries. At this level, CNMs can not afford to serve the Medicare population.

Legislation has been introduced this fall in Congress to raise the payments to 95 percent of the physician fee schedule. The CNM Medicare Services Act of 1999 (HR 2817) is a bipartisan bill that will strengthen the Medicare program. Dramatic cost savings can be achieved by using nurse-midwives. It is estimated that for every $1 million invested in nurse-midwifery education, there could be a saving of $6 million in health care costs annually. (Summary findings: "Nurse Midwifery Care for Vulnerable Populations in the United States," October 1994, grant funded by the Robert Wood Johnson Foundation).

As has just been discussed, preventive health, a proven cost containment strategy, is an integral part of nurse-midwifery care. The lower costs of labor and birth care, when managed by nurse-midwives, is partly due to a judicious use of technology. Less reliance on routine electronic fetal monitoring and ultrasound, reduced need for medication and epidural anesthesia, fewer routine episiotomies, and fewer cesarean sections reduce costs without compromising quality of care.

A recent study commissioned by the Centers for Disease Control and published in *The Journal of Epidemiology & Community Health* (May, 1998) shows that nurse-midwives' outcomes are excellent when compared to those of physicians. The study of 3.5 million births compared physician's and CNM's outcomes in the U.S. in 1991, and after controlling for various risk factors, reported the following outcomes:

1. The risk for neonatal mortality was 33 percent lower for births attended by CNMs.
2. The risk of delivering a low birth weight infant was 31 percent lower for CNM attended births.
3. The mean birth weight was 37 grams higher for CNM attend births.
4. The infant mortality rate was 19 percent lower for CNM attended births than for physician attended births.

Currently, the Medicare program does not recognize free-standing birth centers. Birth centers are non-hospital facilities organized to provide family -centered maternity care and primary care services for women evaluated to be at low risk for obstetrical complications.

In 1975, the Maternity Center Association established the first urban birth center in New York City. Birth centers have also been developed to serve rural communities, such as the Monroe Maternity Center in Madisonville, Tennessee. Today there are 145 such facilities.

The excellent quality of care, accompanied by great cost-savings, has been demonstrated in many research studies. *The New England Journal of Medicine* (12/28/89) reported that:

> Few innovations in health service promote lower cost, greater availability, and a high degree of satisfaction with a comparable degree of safety. The results of this study suggest that modern birth centers can identify women who are at low risk for obstetrical complications and care for them in a way that provides these benefits.

Specifically the study found that:

• The quality of care in birth centers reported in the "The National Birth Center Study" reflects the low overall intrapartum and neonatal mortality rate of 1.3/1000

births; 0.7/1000 if lethal anomalies are excluded. These rates are comparable to studies of low risk, in-hospital births.[1]

• The cesarean section rate for women receiving care in birth centers averages 4.4 percent, approximately one half the rate reported in studies of low risk births in hospitals.[1]

• Birth centers nationally have consistently displayed charges for care for normal birth that average up to 50 percent less than regular hospital stays and 30 percent less than short stays—including practitioner fees.[2, 3]

• More than half of birth centers include routine laboratory exams, childbirth education, home visits, extra office visits, and initial newborn examinations in their charges.

• Most major health insurers contract with birth centers for reimbursement. Because charges reflect cost and since the birth center is a single service unit, there is no opportunity for cost shifting or operating the birth center as a "loss leader" to other services.

• 98.8 percent of women using the birth center would recommend it to friends and/or return to the center for a subsequent birth.[1]

The most recent data released by the Health Insurance Association of America and the National Association of Childbearing Centers showed that in 1995 there was a cost savings of over $3,000 per birth when comparing a vaginal birth at a birth center to a hospital.

1995/Charges:

• Birth Centers Birth: $3,3241
• Hospital Vaginal Births: $6,378
• Hospital Cesarean Births: $10,638

If only 25,000 Medicare births were attended in birth centers, not only would access to care be greatly improved, annual savings could be almost $78.5 million. Plus, for every 500 women that birth centers prevent from having a cesarean birth, savings could equal $3.7 million. This savings to the payers of care has been consistently shown for more than two decades of birth center operation.

The CNM Medicare Services Act (HR 2817) will include accredited free-standing birth centers in the Medicare program.

SUMMARY

The ACNM believes that the lack of recognition for the contributions of CNMs and birth centers must be addressed by a concentrated effort to eliminate unnecessary payment restrictions to nurse-midwifery practices at the federal level. Therefore, we seek the Subcommittee's support for HR 2817.

Statement of the American Counseling Association, Alexandria, VA

The American Counseling Association (ACA) is the nation's largest non-profit membership organization representing professional mental health counselors. Counselors are master's-degreed mental health providers, licensed or certified in 45 states and the District of Columbia. Under the typical standards required for licensure, counselors must complete a master's degree in counseling, accumulate two years and 3,000 hours of post-master's supervised experience, and pass a national examination. Licensed professional counselors practice in a variety of settings, including private practice, clinics, agencies, health plans, hospitals, and group practices.

ACA strongly supports efforts by Congress to modernize and strengthen the Medicare program. With an increasingly large segment of the U.S. population entering eligibility for the program, it is imperative that Medicare provide effective care in an efficient manner. We believe any effort to strengthen Medicare must do so in part by improving beneficiaries' access to mental health care.

Older Americans are not getting the mental health treatment they need. According to testimony from the National Institute of Mental Health delivered at a Senate Special Committee on Aging hearing in 1996, of the older Americans in need of

[1] *Rooks, J., et al., "Outcomes of Care in Birth Centers: The National Birth Center Study," New England Journal of Medicine, 321:1804–1811, (December 28), 1989.*

[2] Health Insurance Association of America, Source Book of Health Insurance Data—1996, 1196, Washington, DC.

[3] National Association of Childbearing Centers, NACC 1996 Annual Survey Report of Birth Centers Experience, 1997, Perkomenville, PA.

mental health care, only an estimated one in three receives care from a mental health professional. Approximately one-third of this population receives no care at all, and another third receives care only through a primary care physician.[1] According to other testimony presented at the hearing, those over age 65 are more likely to commit suicide than any other age group[2], and of the elderly who commit suicide, more than ¾ths had visited a primary care physician within the month before their suicide, and 35 percent had done so within the past week.[3]

As with all other populations and demographic groups, inadequate treatment of mental disorders among the elderly leads to higher general medical care costs. Medicare enrollees with untreated severe depression experience general health care costs roughly 91 percent greater than those without depression, and it is estimated that if only 25 percent of Medicare enrollees with depression were effectively treated, the system would save about $500 million per year.[4] Depression is only the most common, and not the only, mental disorder experienced by older Americans.

Policy analysts, members of Congress, and Congress's own Congressional Budget Office have all stated that important keys to improving patient care while constraining costs are increasing choice and competition within the Medicare program. In the area of mental health, one of the ways in which choice and competition can be added to the system is through the reimbursement by Medicare of the services of licensed professional counselors.

In the private sector, the vast majority of health plans contract with or employ licensed professional counselors in providing services to plan enrollees. Licensed professional counselors (LPC's) are master's degreed mental health providers, meeting education, training, and examination requirements virtually identical to those of clinical social workers. Professional counselors are licensed or certified in 45 states and the District of Columbia, and are recognized as core mental health professionals by the Health Resources and Services Administration, the federal Center for Mental Health Services, and under the Public Health Service Act.

Patient choice of provider is important in all forms of health care, but perhaps is most important in the area of mental health treatment. Under current Medicare law beneficiaries are precluded from seeing licensed professional counselors, even though an LPC may be the beneficiary's first choice of provider. Anecdotal evidence suggests that many older Americans feel more comfortable seeing a counselor than a psychiatrist or a psychologist, or than confiding highly personal mental or emotional problems in his or her primary care physician. In many cases, counselors with good working relationships with primary care or other physicians have older patients referred to them by the physician, and must inform the patient that counselors' services are not covered by Medicare. This fact usually comes as a surprise to the physician.

Access to care is also an issue for older Americans, who often do not have ready access to reliable transportation. In many areas and communities, a counselor may be the only mental health specialist available. Consequently, current Medicare policy both limits choice of provider for program enrollees and makes mental health care less accessible.

Coverage of LPC's under Medicare would not represent the addition of a new type of benefit. Counselors provide the same types of psychotherapy and counseling currently provided under the program by psychologists and clinical social workers, and coverage of counselors would increase competition in the program. This analysis has been borne out by the experience of states which have enacted counselor coverage laws. According to a 1996 survey by the Texas Department of Insurance, payments to licensed professional counselors amounted to only ⅒th of 1 percent of total claims paid by insurers.[5] In the private sector, professional counselors typically charge roughly the same rates as clinical social workers for therapy sessions, and charge less than is charged by clinical psychologists.

In summation, any attempt to increase competition and consumer choice in the Medicare program and to reduce the costs of inadequate mental health treatment for beneficiaries should include recognizing licensed professional counselors under the program. Medicare beneficiaries deserve the same choice of provider and access to high-quality services as is enjoyed by those with private insurance. Current Medicare policy is not meeting the mental health needs of its enrollees.

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[1] Senate Special Committee on Aging, *Treatment of Mental Disorders in the Elderly: Reducing Health and Human Costs,* 104th Congress, 2nd session, 1996, 46.

[2] Senate Committee, *Treatment of Mental Disorders in the Elderly,* 2.

[3] Senate Committee, *Treatment of Mental Disorders in the Elderly,* 42.

[4] Senate Committee, *Treatment of Mental Disorders in the Elderly,* 78.

[5] Texas Department of Insurance, *Health Insurance Regulation in Texas: The Impact of Mandated Health Benefits,* report to the Texas Legislature, 1998, 57.

ACA looks forward to working with members of Congress to bring Medicare's mental health coverage up to date.

Statement of American Medical Association

The American Medical Association (AMA) appreciates the opportunity to submit this written testimony for consideration by the Ways and Means subcommittee on Health and requests that it be included in the printed record.

The AMA applauds the efforts of the members of this subcommittee for focusing on this important issue. For years the AMA has been a strong advocate of basic, essential reforms of the Medicare program. It is clear that the system, as currently structured, cannot continue to support the provision of quality medical services to the elderly and disabled in this country, particularly as the baby boom generation becomes Medicare-eligible while at the same time the numbers of employees in the workforce who financially support the system dwindle.

Congress has already acknowledged that Medicare must be reformed to keep the promise of health care for this and future generations of elderly Americans, as represented by the establishment under The Balanced Budget Act of 1997 (BBA) of the National Bipartisan Commission on the Future of Medicare. We urge, however, that this subcommittee and Congress not delay in passing badly needed reform. Now is the time, before the new millennium, to fix the Medicare program.

Medicare's current tax-based "pay-as-you-go" financing structure makes it highly unlikely that the promise of health care to our elderly can be sustained in the coming years. Moving Medicare from an open-ended entitlement system to one in which the government makes a contribution that allows individuals to have meaningful choice and quality care is the key to gaining budgetary control over outlays.

FOR THE LONG TERM: DEAL WITH THE TRUST FUND MYTH

Because the term "trust fund" is officially used to describe the financing of Medicare, many people think that the payroll taxes they pay are saved and accumulate interest to pay for their personal medical needs in retirement. In fact, the Part A program is financed on a "pay-as-you-go" basis, with taxes paid into the program being used to pay for the benefits received by current retirees, and the excess used to purchase federal debt. Part B is financed mostly out of general revenues, with the premiums that retirees pay calculated to cover only about 25% of the outlays. Part B is modeled after private sector health plans, with a significant difference: beneficiaries fund only 25% of the cost of their services through premiums, leaving taxpayers to fund a significant portion of the remaining cost of providing Part B services.

Most retirees have received much more in benefits than their contributions to the program could purchase. The pay-as-you-go financing is often likened to a "Ponzi" or "pyramid" scheme. The similarity lies in the promise of future benefits to those who fund services for current beneficiaries, and the need for a growing number of new contributors to fund the growing number of beneficiaries. Pyramid schemes, almost by definition, must eventually collapse from an insufficient influx of new participants. The number of workers contributing payroll taxes to finance the current hospital trust fund is declining. In 1965 when Medicare was enacted, there were 5.5 working-age Americans for every individual over age 65. Today, there are only 3.9 workers supporting each Medicare-age individual. In the coming decades, as the "baby boom" generation continues to age, this number will fall more rapidly. By the year 2030, it is estimated that there will be only 2.2 working-age Americans for each individual over age 65. By that time, Medicare will enroll 20% of the population, compared with the 12.8% of the population now enrolled.

Medicare's actuaries base their calculations for funding the Medicare fee-for-service program on the assumption that the rate of health care cost inflation will be controlled over the next 25 years. This assumption allows them to project a significantly lower tax increase needed to fund the program than would be needed if the historical rate of cost inflation continued. Continuing the "pay-as-you-go" system of financing Medicare will impose an ever-increasing burden on working U.S. taxpayers. While this country's obligations to those who are and will be dependent on Medicare in the future must clearly be honored, we need to implement reforms so that the program is available for future generations.

How would we design Medicare if we had it to do over again? How would we protect the younger generations that will face ever-increasing taxes and prospects of eroding benefits and less choice if the current program were to be continued?

To restore the viability of the program's promise to future generations, certain immediate priorities must be met, including shifting away from the "pay-as-you-go" system; establishing a system under which the government makes a contribution that allows individuals to have meaningful choice and quality care; and improving the fee-for-service Medicare program.

This will assure that all working Americans have access to health care in retirement and will maintain choice and quality of care for the elderly.

IMPROVING FEE-FOR-SERVICE MEDICARE

Despite the establishment of and focus on Medicare+Choice, 85% of Medicare beneficiaries receive health care through the Medicare fee-for-service program. It is imperative to improve the efficiency of the fee-for-service program, thereby constraining Medicare's cost growth at a reasonable level over the next several decades and limiting out-of-pocket costs incurred by beneficiaries. The AMA proposes the following structural modifications to the program that would save both beneficiaries and the government money by providing needed incentives for efficiency.

The Path to Scoreable Savings: Eliminate the "Gap" Problem

The large cost imposed on the Medicare program and beneficiaries by the "Medigap problem" has long been recognized as a potential source of significant government budget savings. When Medicare's intended cost sharing is covered by private supplemental insurance (Medigap), it has been demonstrated that beneficiaries use more services than they would otherwise. Since more than 75% of beneficiaries own such supplemental coverage, Medicare's outlays are considerably higher than they would be if the cost sharing were not subverted by Medigap insurance.

Effectively solving this problem presents the best source of scoreable budget savings because the savings produced are the result of efficiency improvements, rather than from imposing additional costs on taxpayers, beneficiaries or providers of medical care.

The potential cost sharing exposure for beneficiaries under the current system can reach more than $34,000 per year since, unlike most private insurance policies, Medicare does not place a ceiling on the out-of-pocket cost that beneficiaries can be required to pay. The current system is designed so that the beneficiary's rational response is to purchase supplemental coverage, which over three-quarters of beneficiaries do as a hedge against economic catastrophe. This occurs, despite the fact that 20% of beneficiaries incur no actual cost sharing liability each year, while 70% incur a cost sharing liability under $500 and 80% incur under $1000 of expense. The risk of paying tens of thousands of dollars out-of-pocket is not one that most beneficiaries want to take.

It is safe to assume that if beneficiaries were not exposed to such potentially high out-of-pocket costs, they (and/or their former employers who provide insurance to supplement Medicare as a retirement benefit) would not feel compelled to insure against it. In fact, the government does not need to expose beneficiaries to such high risk, precipitating the increased burden on beneficiaries and its own budget. The government can give beneficiaries and their former employers an economic break by eliminating their need for supplemental coverage. In so doing, the government can also lessen the pressure that Medigap puts on the federal budget.

The AMA proposes that Medicare restructure its cost sharing to reduce potential beneficiary liability in a manner that eliminates the need for private Medigap insurance. In exchange, beneficiaries would pay a somewhat higher premium than they do now, but they would also have more money available to help cover out-of-pocket costs, such as prescription drugs that are not currently covered by Medicare. The premium charged by Medicare for the expanded coverage would be much less than that charged by private insurance companies because the government's premium would not be padded by marketing expense and profit.

The reinstitution of effective cost sharing would reduce government outlays for medical services. The balance to be struck would be one in which beneficiaries would be provided an effective incentive to reasonably moderate their demand for covered services, while eliminating their need to insure against an enormous potential out-of-pocket liability.

One alternative that the AMA has developed is for Medicare to convert its current cost sharing into a modest deductible with no coinsurance requirement above the deductible, and charge a fair premium for the extra coverage implied by lowering the cost sharing. In this way, beneficiaries would readily know in advance the maximum liability to which they would be exposed. In turn, few would be motivated to buy supplemental insurance (which would no longer be valuable because its pre-

mium cost would meet or exceed the liability it would be purchased to insure against). Beneficiaries would be trading the unknown for the known.

As an illustration of this reallocation approach, we estimate that the average cost of the Medigap "Plan C" that covers all of Medicare's potential cost sharing liability as about $1,330 in 1999. This amount could be divided into two parts, consisting of a modest, single deductible for both Parts A and B of Medicare, and a premium for the extra Medicare coverage represented by eliminating all existing cost sharing liability except for the single deductible. Dividing the current cost of Medigap Plan C into two parts—a deductible and a premium for extra coverage—would guarantee that beneficiaries would incur no greater out-of-pocket expense than they do now, and many of them would actually save money.

For example, consider dividing the current Medigap cost into a $500 deductible and a premium of $830. According to the most recent actuarial analysis by PriceWaterhouse, the average beneficiary would spend only $400 of the $500 deductible, saving $100 per year from the cost of $1,330 for Medigap. By neutralizing the first-dollar-coverage incentive of Medigap, the Medicare program would save an average of $334 per beneficiary, which could be returned to beneficiaries in the form of reduced Part B premiums or additional coverage. If the government savings were used to reduce the deficit, a total of $40 billion of savings would accrue over the 5-year budget period 1999–2003.

Medicare's current cost sharing requirements are self-defeating because they frighten beneficiaries into insuring against them with expensive private coverage. By incorporating most of Medigap's coverage into Medicare benefits, the government could save beneficiaries money by reducing the premium required for the coverage. In turn, the government can achieve the intended benefit of effective cost sharing to reduce program expenditures.

Neutralizing Medigap is a "win" for patients and beneficiaries, the government and taxpayers. For example, we understand that Congress and the Administration are exploring various methods to help beneficiaries pay the exorbitant cost of pharmaceutical drugs. As discussed above, it is expected that beneficiaries' out-of-pocket costs will almost double over the next couple of decades. A significant portion of those costs will be for pharmaceutical drugs that are covered by the Medicare fee-for-service program, which CBO projects will increase between 13% and 21% each year during the next decade. The savings received by beneficiaries as a result of eliminating the Medigap problem will help offset the cost of the drugs.

Even if Congress does not enact broad program restructuring now, we urge Congress to avoid approving legislation in the interim that would either:

- increase beneficiary uncertainty regarding potential out-of-pocket costs, which will drive up demand for Medigap insurance;
- increase availability of first-dollar coverage for covered Medicare benefits, which will promote inefficient utilization of services, thus driving up program costs; or
- greatly expand Medicare benefits in a manner that adds significantly to Medicare's future financing problems.

Improving Medicare's Sustainable Growth Rate System

Improving Medicare's sustainable growth rate (SGR) system is a major priority for the physician community. We urge inclusion of legislation to fix the problems with the SGR in any legislation approved by the Committee to reform Medicare or refine elements of the Balanced Budget Act of 1997.

Enacted under the BBA, the SGR establishes a target growth rate for Medicare spending on physician services, then annually adjusts payments up or down, depending on whether actual spending is below or above the target. The SGR system was intended to slow the projected rate of growth in Medicare expenditures for physicians' services.

Physicians are the only group subject to this target, despite the fact that Medicare spending on physician services has been growing more slowly than other Medicare benefits. Although the BBA included measures to slow projected growth in these other benefits, the Congressional Budget Office continues to forecast much higher average annual growth rates for other services than for physician services over the next decade. In contrast to annual growth in outlays of 4.6 percent for inpatient hospital services, 5.7 percent for skilled nursing facilities, 6.5 percent for home health, and 14.6 percent for Medicare+Choice plans, average annual growth in physician services is projected at only 3.1 percent from 2000–2009.

Physicians were subject to significant and disproportionate Medicare payment cuts prior to the BBA, yet we have never abandoned our elderly and disabled patients. From 1991–97, physician payment updates already had slipped 10 percent below growth in medical practice costs.

In its March 1999 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) identified serious problems in the SGR system and recommended significant improvements to it. The AMA and the national medical specialty societies share MedPAC's concerns and believe that improving the SGR is a critical component of efforts to ensure that the 85 percent of Medicare beneficiaries who are enrolled in the fee-for-service program continue to receive the benefits to which they are entitled.

Specifically, the physician community is concerned that the growth limits in the current SGR system are so stringent that they will have a chilling effect on the adoption and diffusion of innovations in medical practice and new medical technologies. In addition, we are concerned that the Health Care Financing Administration (HCFA) did not revise the projections it used in the 1998 SGR when data proved HCFA erroneous. Further, HCFA stated it will not correct 1999 SGR errors without a congressional mandate, despite that in the first two years of the SGR, erroneous HCFA estimates have already shortchanged the target by more than $3 billion. Finally, we are concerned that the SGR could also cause future payments to be highly volatile and fall well behind inflation in practice costs.

Medicare Physician Payments and the BBA: Medicare payments for physicians' services are updated annually by HCFA. Payment rates are based on a relative value scale system, enacted under OBRA 89, that reflects the physician work, practice expense and professional liability insurance costs involved in each service. The relative value for each service is multiplied by a dollar conversion factor to establish actual payment amounts. The conversion factor is required to be updated each calendar year, which involves, in part, establishing an update adjustment factor that is adjusted annually by the SGR.

MedPAC recommends, and the AMA agrees, that Congress revise the SGR system as follows:

- The SGR should include a factor of growth in real gross domestic product per capita plus an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology,
- The Secretary should be required to publish an estimate of conversion factor updates by March 31 of the year before their implementation;
- The time lags between SGR measurement periods should be reduced by allowing calculation of the SGR and update adjustment factors on a calendar year basis;
- HCFA should be required to correct the estimates used in the SGR calculations every year; and
- The SGR should reflect changes in the composition of Medicare fee-for-service enrollment.

The SGR system was enacted under the BBA and replaces the Medicare Volume Performance Standard system, which had been the basis for setting Medicare conversion factor updates since 1992. The SGR sets a target rate of spending growth based on four factors: changes in payments for physician services before legislative adjustments (essentially inflation); changes in Medicare fee-for-service enrollment; changes in real per capita gross domestic product (GDP); and an allowance for legislative and regulatory factors affecting physician expenditures. Growth in real per capita GDP represents the formula's allowance for growth in the utilization of physician services.

The target rate of spending growth is calculated each year and is designed to hold annual growth in utilization of services per beneficiary to the same level as annual GDP. Physician payment updates depend on whether utilization growth exceeds or falls short of the target rate. If utilization growth exceeds GDP, then payment updates are less than inflation. If utilization is less than GDP, payment updates are above inflation.

Because of the serious problems with the SGR system, as discussed below, four improvements must be included in legislation to fix the SGR:

- There must be a requirement to correct HCFA's projection errors and to restore the $3 billion SGR shortfall resulting from these errors;
- The SGR must be increased to account for physician costs due to adoption of new technology;
- Measures must be implemented to curtail volatility in physician payment rates and avoid steep cuts in the future; and
- HCFA and MedPAC must be required to provide information and data on payment updates.

Problems with the SGR System: Of the needed improvements listed above, we wish to focus on two major problems with the SGR. First, there is a "projection error" problem. Specifically, in determining the SGR each year, HCFA must estimate certain factors that are used to calculate the SGR. In the first two years of the SGR system, HCFA has seriously miscalculated these factors, and thus physi-

cians have been shortchanged by several billion dollars. In addition, these projection errors will continue each year, and the resulting shortfalls will be compounded. Second, the SGR system does not allow growth in physician payments sufficient to account for physicians' costs due to technological innovations.

Unlike some other Medicare payment issues, the problems with the SGR system and their solutions are a matter on which the physician community is unified. National organizations representing diverse medical specialties, including surgeons, primary care physicians and others, as well as organizations representing medical colleges and group practices, have been working closely together with the AMA to address these complex issues. On behalf of the entire physician community, we are asking Congress to take the necessary steps to assure that we can continue to afford to provide our Medicare patients with the best medical care available in the world.

I. *The Projection Error Problem.*—Two of the four factors used to calculate the SGR target each year are growth in U.S. GDP and fee-for-service enrollment growth. Because the target must be calculated before the year begins, HCFA can only speculate as to what GDP growth will be and how many people will enroll in fee-for-service versus managed care. Recognizing the need for such speculation, HCFA acknowledged in a 1997 physician rate update regulatory notice that the actual data for each year, once available, might reveal errors in its estimates of as much as 1 percent, or $400 million. HCFA also promised that the difference between its projections and actual data would be corrected in future years.

In the first two years of the SGR, erroneous HCFA estimates have already shortchanged physician payments by more than $3 billion. These projection errors have not been corrected and HCFA does not plan to do so. Specifically, one year after the 1997 notice, HCFA reneged on its pledge to correct SGR errors and simultaneously issued its most egregious error, projecting Medicare managed care enrollment would rise 29 percent in 1999, despite the many HMOs abandoning Medicare in 1999. This error led, in turn, to a projected drop in fee-for-service enrollment and a *negative* 1999 SGR. Data now show that managed care enrollment has increased only 11 percent, a fraction of HCFA's projection, which means *physicians are caring for 1 million more patients in Medicare fee-for-service than were forecast.*

The 1998 and 1999 SGR projection errors are a serious problem. The SGR is a cumulative (as opposed to an annual) system, and the cumulative SGR target is like a savings account for physician services. As discussed, HCFA's errors have left a $3 billion shortfall in this account, which, if not restored, will either produce unwarranted payment cuts or deficient payment increases. Although the President's 2000 budget proposes to address the projection errors, we are concerned that HCFA may correct the errors in a way that will effectively cancel any benefit to payment rates from using accurate data.

Physicians have faced a decade of payment cuts without ever abandoning Medicare patients. We have done our part to keep costs within the limits imposed by the BBA. Now, Congress must do its part by insisting that payment updates be based on correct SGR estimates.

II. *The SGR Must Allow for Technological Innovations and Other Factors Impacting Utilization of Health Care Services.*—MedPAC has also recommended that Congress revise the SGR to include a factor of growth in real gross domestic product per capita plus an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology.

The system is currently designed to hold annual utilization growth at or below annual GDP growth. A common method for policymakers to evaluate trends in national health expenditures is to look at growth in health spending as a percentage of GDP, but this approach is replete with problems. There is no true relationship between GDP growth and health care needs. Forecasts by Congressional Budget Office and the U.S. Census Bureau indicate that real per capita GDP growth will average about 1.5 percent per year over the next decade. This is far below historical rates of Medicare utilization growth. Indeed, at 5.9 percent, average annual per beneficiary growth in utilization of physicians' services was three to four times higher than GDP growth from 1981–1996. Thus, if history is any guide, holding utilization growth to the level of GDP growth virtually guarantees that Medicare physician payments will decline.

A primary reason for this lack of congruity between GDP and Medicare utilization is that GDP does not take into account health status trends nor site-of-service changes. Thus, if there were an economic downturn with negative GDP growth at the same time that a serious health threat struck a large proportion of Medicare beneficiaries, the consequences could be disastrous.

Secondly, GDP does not take into account technological innovations. The only way for technological innovations in medical care to really take root and improve standards of care is for physicians to invest in those technologies and incorporate them

into their regular clinical practice. The invention of a new medical device cannot, in and of itself, improve health care—physicians must take the time to learn about the equipment, practice using it, train their staff, integrate it into their diagnosis and treatment plans and invest significant capital in it. Yet physician spending is the only sector of Medicare that is held to as stringent a growth standard as GDP and that faces a real possibility of payment cuts of as much as 5 percent each year. Keeping utilization growth at GDP growth will hold total spending growth for physician services well below that of the total Medicare program and other service providers.

To address this problem, as recommended by MedPAC, the factor of growth under the SGR relating to GDP must be adjusted to allow for innovation in medical technology. We believe to implement adequately MedPAC's recommendation, the SGR should be set at GDP + 2 percentage points to take into account technological innovation, as discussed further below.

In addition, we urge that Congress consider a long-term approach to setting an appropriate growth target that takes into account site-of-service changes, as well as health status and other differences between Medicare's fee-for-service and managed care populations that lead to differential utilization growth. Thus, we believe that the Agency for Health Care Policy and Research (AHCPR) should be directed to analyze and provide a report to MedPAC on one or more methods for accurately estimating the economic impact on Medicare expenditures for physician services resulting from: improvements in medical capabilities and advancements in scientific technology; changes in the composition of enrollment of beneficiaries under the fee-for-service Medicare program; and shifts in usage of sites-of-service.

Technological Advances: Congress has demonstrated its interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process. The benefits of these efforts could be seriously undermined if physicians face disincentives to invest in new medical technologies as a result of inadequate expenditure targets.

As first envisioned by the PPRC, the SGR included a 1 to 2 percentage point add-on to GDP for changes in medical technology. Ever-improving diagnostic tools such as magnetic resonance imaging, new surgical techniques including laparoscopy and other minimally-invasive approaches, and new medical treatments have undoubtedly contributed to growth in utilization of physician services and the well-being of Medicare beneficiaries. For example, a recent paper published by the National Academy of Sciences indicated that from 1982–1994 the rates of chronic disability among the elderly declined 1.5 percent annually.

With GDP projected to grow by 1.5 percent annually, the failure to allow an additional 1 to 2 percentage points to the SGR for technological innovation means that the utilization target is only half the rate that was originally planned. *Technological change in medicine shows no sign of abating, and the SGR should include a technology add-on to assure Medicare beneficiaries continued access to mainstream, state-of-the art quality medical care.*

Site-of-Service Shifts: Another concern that should be taken into account by the GDP growth factor is the effect of the shift in care from hospital inpatient settings to outpatient sites. As MedPAC has pointed out, hospitals have reduced the cost of inpatient care by reducing lengths-of-stay and staff and moving more services to outpatient sites, including physician offices. These declines in inpatient costs, however, are partially offset by increased costs in physician offices. Thus, an add-on to the SGR target is needed to allow for this trend.

Beneficiary Characteristics: The SGR should also be adjusted for changes over time in the characteristics of patients enrolling the fee-for-service program. A MedPAC analysis has shown that the fee-for-service population is older, with proportions in the oldest age groups (aged 75 to 84 and those age 85 and over) increasing, while proportions in the younger age group (aged 65–74) has decreased as a percent of total fee-for-service enrollment. Older beneficiaries likely require increased health care services, and in fact MedPAC reported a correlation between the foregoing change in composition of fee-for-service enrollment and increased spending on physician services. *If those requiring a greater intensity of service remain in fee-for-service, the SGR utilization standard should be adjusted accordingly.*

III. *Other Problems with the SGR System.*—The AMA strongly agrees with MedPAC's further recommendation that Congress should stabilize the SGR system by calculating the SGR and the update adjustment factor on a calendar year basis.

Instability in annual payment updates to physicians is another serious problem under the SGR system, as has been acknowledged by HCFA. Projections by the AMA, MedPAC and HCFA show the SGR formula producing alternating periods of

maximum and minimum payment updates, from inflation plus 3 percent to inflation minus 7 percent. Assuming a constant inflation rate, these alternating periods could produce payment decreases of 5 percent or more for several consecutive years, followed by increases of similar magnitude for several years, only to shift back again. These projections are based on constant rates of inflation (2 percent), enrollment changes, GDP growth and utilization growth. There is a serious problem when constant, stable rates of change in the factors driving the targets lead to extreme volatility in payments that are entirely formula-driven.

A primary reason for this instability is the fact that there is a time lag in measurement periods for the SGR. Specifically, while physician payment updates are established on a calendar year basis, SGR targets are established on a federal fiscal year basis (October 1 through September 30) and cumulative spending (used to calculate the SGR) is established on an April 1 through March 31 basis. These time periods must all be consistent and calculated on a calendar year basis to attempt to restore some modicum of stability to the SGR system.

Simulations by the AMA and MedPAC have also shown, however, that the change to a calendar year system will not, by itself, solve the instability problem. Additional steps would be needed. The wide range of updates that are possible under the current system, from inflation + 3 percent to −7 percent, is one reason for the instability. The lower limit is also unacceptably low, and, assuming an MEI of 2 percent, represents an actual 5 percent cut in the conversion factor in a single year. These levels of payment cuts would be highly disruptive to the market, and likely would have the "domino effect" of impacting the entire industry, not simply Medicare fee-for-service. Many managed care plans, including Medicare+Choice and state Medicaid plans, tie their physician payment updates to Medicare's rates. *Thus, payment limits under current law must be modified to assist in stabilizing the SGR system. We recommend that the current limits on physician payment updates (MEI +3 percent to MEI −7 percent) be replaced with new, narrower limits set at MEI +2 percent and MEI −2 percent.*

Use of the GDP itself also contributes to the instability of the payment updates since GDP growth fluctuates from year to year. *Thus, we recommend measuring GDP growth on the basis of a rolling 5-year average.*

Finally, MedPAC has also recommended that Congress should require the Secretary of the Department of Health and Human Services to publish an estimate of conversion factor updates prior to the year of implementation. We agree.

When the SGR system was enacted to replace the previous Medicare Volume Performance Standards, the requirements for annual payment review reports from HCFA and the PPRC were eliminated along with the old system. Without these reports, it is impossible to predict what the payment update is likely to be in the coming year, and it is impossible for Congress to anticipate and respond to any potential problems that may ensue from an inappropriate update or a severe projection error.

Changes in Medicare physician payment levels have consequences for access to and utilization of services, as well as physician practice management. These consequences are of sufficient importance that the system for determining Medicare fee-for-service payment levels should not be left unattended on a kind of "cruise control" status, with no "brake" mechanism available to avoid a collision.

The AMA, therefore, urges that the payment preview reports be reinstated. Specifically, we believe that HCFA should be required to provide to MedPAC, Congress and organizations representing physicians quarterly physician expenditure data and an estimate each spring of the next year's payment update. MedPAC could then review and analyze the expenditure data and update preview, and make recommendations to Congress, as appropriate.

The Importance of Fixing the SGRL: Enactment of the SGR system improvements recommended by MedPAC are critical to the continued ability of our nation's physicians to be able to offer our Medicare patients the benefits of the finest medical care available in the world. If these improvements are not put in place, the SGR system could lead to severe payment cuts in the Medicare physician fee schedule and payments for services that do not accurately reflect their costs. The cuts resulting from both the statutory design of the SGR system and administration of the system by HCFA would be in addition to more than a decade of cuts in physician payments. For example, in the six years from 1991–1997, overall Medicare physician payment levels fell 10 percent behind the rate of growth in medical practice costs. Many individual services and procedures faced even deeper cuts.

Recent survey data from the AMA's Socioeconomic Monitoring System indicates that these payment changes are having very significant effects on the practice of medicine. Of 2,450 randomly selected physicians that were surveyed from April-August 1998, 35 percent reported they are not renewing or updating equipment used in their office, are postponing or canceling purchasing equipment for promising new

procedures and techniques, or are performing many procedures in hospitals that were formerly performed in the office. Three quarters of these physicians reported that Medicare payment cuts were an important factor in their decisions to defer or cancel these investments in capital.

With these kinds of changes already taking place in response to previous payment changes, we have grave concerns about the effects of the further reductions that could take place due to the SGR or incorrect practice expense values. In order for the medical innovations that will come from Congress' enhanced funding of biomedical research, FDA modernization, and better Medicare coverage policies to translate into ever-improving standards of medical care, physicians must be able to adopt these innovations into their practices. It is already clear that Medicare payment cuts are threatening continued technological advancement in medicine, and this is a threat that affects all of us, not just Medicare beneficiaries. Clearly, reversal of the trend to move services away from inpatient sites into ambulatory settings could also have severe consequences for health care costs, as well as patient care.

Additional Modifications to Fee-For-Service Medicare

There are several other considerations that we believe are necessary for reforming fee-for-service Medicare. First, Medicare reform legislation must address funding for graduate medical education. We believe that a national all-payer fund should be established to provide a stable source of funding for the direct costs of GME, including resident stipends and benefits, faculty supervision and program administration and allowable institutional costs. Without predictable and reliable funding, this important training program is seriously undermined, with a resulting adverse impact on patient care.

Additionally, other issues should be addressed as well, including increasing the age of Medicare eligibility to match the eligibility requirements for purposes of Social Security and establishing income-related premium payments for Medicare benefits.

The AMA is also aware that there is interest among a number of states in allowing them to make managed care enrollment mandatory for dually-eligible Medicare and Medicaid beneficiaries. State medical societies have told us of numerous serious problems in states with mandated Medicaid managed care programs for their non-Medicare populations, including Tennessee, Kentucky, Massachusetts, Florida, Nebraska, Washington, and others. Given the current instability within both Medicare and Medicaid managed care plans, we urge Congress not to extend the states' authority to mandate managed care enrollment to their dually-eligible populations.

In addition, we agree with concerns raised by Members of the National Bipartisan Commission on the Future of Medicare about providing HCFA with increased authority to contract for health care services with lowest cost bidders, and believe HCFA's contracting authority should be strictly limited. Such authority often permits HCFA to contract selectively for individual services. Competition should be based on choice of a comprehensive health plan, not with respect to individual services. Proposals that carve out certain services dangerously fail to recognize a crucial dynamic within the health care market. That is, certain services are a mainstay for many providers' economic base. If that base is jeopardized because HCFA has the ability to contract elsewhere for this singular service, the cost of other services offered by that provider will significantly increase, or, worse, the provider may cease to exist due to insolvency. Either alternative is extremely damaging to patients with respect to cost, quality and continuity of care and convenience.

Indeed, AMA policy firmly opposes competitive bidding initiatives for professional medical services with respect to the Medicare program and health care payers generally. First, as discussed above, this type of system threatens a dramatic decrease in quality of and access to medical care. In any bid process, there are always low cost bidders that wish to corner a large share of the market. The low cost bidder may drive competitors out of the market, in which case the bidder will obtain a monopoly and will be free to set prices in an environment that is unconstrained by competition. Since the current health care payer market has become more significantly concentrated, this result would be a significant threat. Additionally, providers, including those that provide the highest quality of care using new state-of-the art technology, will have a strong incentive to provide less costly and lower quality alternatives to maintain competitiveness within a competitive bidding environment. Further, there have been cases when the competitive bidding process has resulted in the procurement of services from organizations that have gone bankrupt, thereby disrupting continuity of and access to care, as well as causing harm to physicians and other providers who rely on a failed contractor for payment. This would be even more damaging if competitors have already been driven from the market.

EVALUATING MEDICARE+CHOICE

Since most Medicare reform plans envision an expanded role for private plans, we believe that it is important to evaluate the new private options mandated under the BBA. Experience to date with the new program called Medicare+Choice suggests several areas which warrant Congressional attention.

To date, Congressional concern has focused primarily on the financial complaints of the traditional managed care plans that have long been part of Medicare. While we agree that the spate of plan withdrawals in 1999 and 2000 have created significant problems for Medicare's 39 million beneficiaries, we think that proposals to correct the situation by increasing payments to plans are short-sighted.

Rather than channeling more funds to these long-time players, lawmakers might have more effect by removing some of the roadblocks that have stymied the entry of other types of plans into Medicare. In addition, with more than 80% of all the nation's elderly and disabled citizens still enrolled in fee-for-service Medicare, it is important to keep that program strong and ensure that it is possible for beneficiaries to return to fee-for-service when their managed care plan withdraws from Medicare. And since there will always be some withdrawals in a market-based program, protecting beneficiaries who find themselves in this situation will be critical to the success of Medicare+Choice and any further reforms that build on private sector initiatives.

Beneficiary Protections

The AMA's House of Delegates has called for additional safeguards for beneficiaries abandoned by their Medicare+Choice plan and we believe that these protections will become even more important as more beneficiaries move into private plans. A number of such provisions have been offered and have bipartisan support and the AMA urges Congress to make the protection of beneficiaries orphaned by their health plan a key part of any Medicare bill it should approve.

Among the protections the AMA would like to see are several that would extend and improve the Medigap guaranteed issue rights included in the BBA. These provisions would provide *all* beneficiaries—including those who have disabilities or End Stage Renal Disease (ESRD)—with the right to purchase Medigap coverage following a plan termination. In addition, they would modify current law to include policies with drug coverage among the Medigap plans that are available to beneficiaries abandoned by their Medicare+Choice plan.

Another thrust of many of the new beneficiary safeguards that have been proposed this year is to let beneficiaries leave a plan as soon as it announces its intent to withdraw from Medicare. Under the BBA, beneficiaries' ability to switch to a new plan or switch back to Medicare fee-for-service, except at the beginning of a new year, will be restricted after 2002. Several proposed amendments would let beneficiaries switch out of a withdrawing plan without waiting until the new year.

The AMA supports these amendments. However, according to the General Accounting Office (GAO), half of the 400,000 orphaned beneficiaries who could have switched to another plan in 1999 returned to fee-for-service Medicare. It is understandable that beneficiaries who have experienced a plan withdrawal should prefer fee-for-service Medicare to another Medicare+Choice plan. *Therefore we believe that in addition to switching to a new plan, beneficiaries should have the right to return to fee-for-service Medicare.* To make this a plausible option, the Medigap guaranteed issue rights should also become available as soon as the beneficiary is notified that his or her plan intends to leave Medicare.

While these steps would protect beneficiaries when their relationship with the plan is severed, they do not address an equally traumatic event: the severing of relationships between patients and their physicians. Medicare patients often pick a particular Medicare+Choice plan because their physician is part of that network. We are also aware of physicians who joined a particular network based on the requests of patients who desire to continue seeing their long-time physician. Maintaining a relationship with a trusted physician is important to patients of all ages. It can be absolutely critical for some frail elderly and disabled patients who are facing serious illness.

That is why the AMA believes that it is of utmost importance that Medicare+Choice plans be required to stress in their marketing materials and brochures that their network of physicians and hospitals may change during the course of the year. *In addition, we believe that Medicare should follow the example of the numerous states that have enacted continuity of care provisions to protect patients when their physician/s leaves their Medicare+Choice plan.*

Essentially, such provisions require plans to continue covering treatment by the departing physician for a specified period of time (usually 60 to 120 days) if the pa-

tient is undergoing a course of treatment, hospitalized or pregnant. The National Committee for Quality Assurance (NCQA) requires a continuation of coverage provision for accreditation of managed care plans. The AMA believes that Medicare should do no less.

The So-Called Fairness Gap

The managed care industry has repeatedly complained that the BBA created a so-called "fairness gap" between managed care and fee-for-service. In the AMA's view, nothing could be further from the truth. *Rather than creating a fairness gap, the BBA in fact began to eliminate a fairness gap that favored the managed care industry with more than a decade of substantial overpayments.*

As evidence that health plans are suffering from a "fairness gap," the industry points to a Price Waterhouse analysis which concludes that by 2004, two-thirds of Medicare+Choice enrollees will live in areas where the Medicare payment for managed care is at least $1,000 less per year than the government spends for each fee-for-service beneficiary in the area. The enrollees in question are characterized as living in the "top 100 counties" (i.e., they live in the counties that have the highest Medicare+Choice rates in the country).

The AMA submits that one of the goals of the BBA was to reduce the differences between payments in the "top" and the "bottom" counties. It is important to remember that about a third of all counties in the U.S. are seeing significant increases in payments for Medicare beneficiaries who enroll in managed care. *In most of these counties, Medicare is now spending more per capita for managed care enrollees than for fee-for-service beneficiaries.*

In other words, there are two sides to this picture. Payment restraints in "top" counties are balanced by payment increases in "bottom" counties. The managed care industry proposes to improve the lot of plans in the "top" counties by having Congress guarantee Medicare+Choice plans payment rates equal to at least 91% of fee-for-service per capita expenditures. Ironically, however, the industry has totally ignored the other side of the equation. *Should Congress also reduce Medicare+Choice payments that exceed fee-for-service rates?*

The Congressional Budget Office (CBO), GAO, Physician Payment Review Commission (PPRC) and Mathematica all have concluded that Medicare overpaid HMOs by 7% to 14% prior to the BBA. In addition, PPRC found some evidence that the excess tended to be greatest in the so-called "top" counties. The BBA reduced these overpayments. But due to an oversight, Congress inadvertently precluded Medicare officials from adjusting 1997 county rates for previous forecast errors, thereby building a $1.3-billion-a-year excess into the Medicare+Choice rates. Moreover, all plans are guaranteed annual payment increases of at least 2% a year.

The AMA therefore agrees with the GAO's conclusion that managed care plans should be able to continue offering supplemental benefits despite the payment modifications enacted in the BBA. In our view, reducing some of the payment and coverage disparities that existed under the Medicare risk program was an intended and desirable impact of those payment modifications. As noted earlier, we also do not agree that payment rates are the key ingredient in the spate of program withdrawals seen to date in the Medicare+Choice program.

As a result, the AMA cannot at this time support amendments that would increase plan payment rates. It would not be fiscally prudent to increase financial incentives to keep plans and beneficiaries in Medicare+Choice if the only way to accomplish this is to pay plans more than it would cost to treat a given beneficiary under Medicare's traditional fee-for-service program. Therefore, our preference is to make across-the-board improvements in both fee-for-service and Medicare+Choice as part of an overall reform strategy.

Risk Adjustment

More than half of all Medicare beneficiaries have covered health care costs of less than $500 a year. Another 5% have costs of more than $25,000 per year and this 5% generate more than half of all Medicare expenditures each year. Clearly any system that makes similar payments on behalf of all patients will overpay for some and greatly underpay for others. Yet that is essentially how Medicare has paid managed care plans until now.

This might not have mattered much if expensive and inexpensive patients were evenly dispersed among plans and between fee-for-service and managed care. For a variety of reasons, however, Medicare beneficiaries choosing managed care have tended to be younger and healthier than those who remain in fee-for-service. A 1996 beneficiary survey indicated that Medicare beneficiaries in fee-for-service are about one-and-a-half times as likely to report poor health as those in managed care. Costs

in the same survey were three to five times higher for beneficiaries in poor health than those in excellent or good health.

Medicare obviously needs to adjust payments to reflect these differences and under the BBA, Congress ordered HCFA to replace the relatively crude demographic adjustment it had previously used with a new risk adjuster that includes health status. Although we are sympathetic to the managed care industry's concerns that the new risk adjuster initially will only be based on hospital data, the AMA believes that the proposed adjustment is a marked improvement over the current system nonetheless.

Although the new adjuster is predicted to reduce aggregate payments to Medicare+Choice plans by 7.6% a year when fully implemented, we note that this will only be the case if plans continue to attract a relatively healthy mix of patients. *If, on the other hand, they enroll a larger number of patients who are seriously ill, their aggregate payments will actually increase.*

The AMA has generally been supportive of transition periods whenever Congress orders significant changes in Medicare payments and we are pleased that HCFA has decided to phase the new risk adjuster in over five years. *However, we cannot support proposals to require the agency to recalculate the rates to guarantee a budget neutral implementation of the risk adjuster.*

Such proposals, in effect, assume that Medicare's total expenditures on managed care have been about right in the past and that we need only to redistribute these payments among plans. However, as noted earlier, most experts agree that Medicare has been paying 7% to 14% more per year for managed care enrollees than for similar beneficiaries who remained in fee-for-service. *A budget neutral risk adjuster would continue that disparity, diverting money that might be better spent in across-the-board program improvements.*

While we are anxious to see improved risk adjusters implemented as soon as possible, the AMA concurs with the managed care industry's contention that better risk adjusters are needed. Risk adjustment will assume an increasingly important role as private sector options are expanded and it is important that HCFA continue to work to develop risk adjusters that can more accurately predict expenses for individual Medicare beneficiaries.

Other Medicare+Choice Issues

Although Congress to date has focused primarily on the withdrawal of managed care plans from Medicare+Choice, the AMA believes that it is just as important to determine how the other private sector alternatives envisioned in the BBA have fared. As the BBA Conference Report observes, private fee-for-service (PFFS) plans represent "the first defined contribution plan. . .in the history of the program." PFFS plans thus could serve as a test case for Medicare reforms that legislators would like to see expanded. In addition, *alternatives such as medical savings accounts and PFFS plans could serve as a viable option to Medicare fee-for-service in some communities that are too small to support managed care.* To date, however, neither of these options is available to Medicare beneficiaries.

As pointed out in a recent study by Families USA, three-quarters of elderly and disabled Americans living in rural counties do not have access to a managed care plan. Moreover, this situation could worsen next year because according to HCFA, a disproportionate number of Medicare+Choice withdrawals in the year 2000 are occurring in rural areas.

There clearly is a need for other Medicare+Choice options in rural communities and a number of analysts had speculated that PFFS plans could fill the void in small communities. That this has not proven true to date likely is due to obstacles that were set up in the legislation and then magnified in the implementing regulations.

One area of particular concern is the so-called "deeming" requirement, which was included in the BBA and then expanded upon in the regulation. Essentially, this provision stipulates that in addition to participating and nonparticipating providers, PFFS plans must create a "deemed" contractor category. Deeming is assumed if "the provider, professional, or other entity has been informed of the individual's enrollment" in a PFFS plan and was either "informed of the terms and conditions of payment" or "given a reasonable opportunity to obtain information concerning such terms and conditions."

This provision is extremely confusing and has no precedent in the real world. It has the potential to disadvantage the so-called "deemed" providers in some circumstances and the PFFS organization in others. The resulting uncertainty will undoubtedly discourage the development of PFFS organizations and should such an organization ever emerge, disputes over "deemed" status are highly likely. Both physi-

cians and their patients could be caught up in endless billing hassles that cannot be easily or quickly resolved.

To make matters worse, the interim final regulation implementing Medicare+Choice appears to create a situation in which a PFFS organization could contend that it had met the "deemed" requirement with a mass mailing to hospitals and physicians or even to billing agencies. Busy hospitals and physicians might not even see the notice. Those that do would have the burden of notifying the plan that they do not intend to participate, accepting payment rates they would not otherwise have agreed to, or turning away any beneficiary enrolled in a PFFS plan.

This situation is particularly problematic for emergency physicians who by law cannot turn away any beneficiary with a real emergency. In addition, all physicians will be in danger of violating PFFS billing rules they knew nothing of, potentially generating a fraud investigation in the process. Medicare beneficiaries could also be disadvantaged if they choose what appears to be a large PFFS network only to discover later that many of the network's physicians were "deemed" to be participating and have now decided not to treat any PFFS patient except in an emergency.

To make the PFFS program tenable and provide a fair test of the defined contribution concept, the AMA believes that the conditions under which deeming can be presumed must be limited. We urge Congress to include amendments to this effect in any Medicare+Choice package that it approves. At the very least, we believe that deeming should never be presumed in any situation where services were required under the Emergency Medical Treatment and Labor Act.

Medicare+Choice plan accountability is another important issue. Currently, we believe plans in this program are being held to a lower standard than is applicable to the Medicare fee-for-service program, especially with respect to payment policy and timeframes. For example, while carriers that process Medicare fee-for-service claims are required to pay 95% of claims within 30 days, there are no deadlines for payments to physicians who contract with Medicare+Choice plans that use fee-for-service reimbursement. There is no reasonable justification for this duality of accountability standards between the Medicare+Choice and Medicare fee-for-service programs. Medicare+Choice plans using fee-for-service reimbursement or that make capitation payments should be held to the same payment deadlines and policies as apply under the fee-for-service program.

Finally, as plans pull out of the Medicare+Choice market, resulting in a significantly more concentrated payer market, there must be checks and balances in place to protect against arbitrary health plan anti-patient actions and to increase quality of care for patients by permitting effective advocacy by their physicians. Physicians increasingly face enormous health plan bureaucracies at the negotiating table, and are thus not in a position to advocate effectively on behalf of their patients. Thus, we strongly urge Congress to pass legislation that would allow self-employed physicians and other health care professionals to engage in joint negotiations with Medicare+Choice plans without violating the antitrust laws.

CONCLUSION

The tax-based method of financing Medicare originally envisioned is no longer sustainable. Putting Medicare on sound financial footing requires a multi-faceted transformation of the program's funding, actuarial design, and incentive structure, as outlined above. We urge this Committee and Congress to consider these proposals and to act now to fulfill the promise of health care for the elderly in this country.

We appreciate the efforts of the members of this subcommittee to explore approaches to Medicare reform, and also appreciate the opportunity to present our reform proposal and comments on the Medicare+Choice program. We are prepared to engage fully in detailed discussions with this subcommittee and Congress as we work to find a common solution.

Statement of Dr. John C. Goodman, President, National Center for Policy Analysis

My name is John C. Goodman and I am president and chief executive officer of the National Center for Policy Analysis. The National Center for Policy Analysis is a non-profit public policy research institute headquartered in Dallas, Texas. We are internationally known for our studies on public policy issues.

My remarks today are drawn from our most recent study on Medicare and prescription drugs prepared for NCPA by Milliman & Robertson, the nation's leading actuarial consulting firm on health benefits.

The results of the Milliman & Robertson study indicate that senior citizens could have comprehensive coverage for prescription drugs in addition to other Medicare benefits—with virtually no increase in personal costs—if private health plans were allowed to administer the benefits.

STUDY FINDINGS

The study finds that private health plans have the ability to eliminate much of the waste and inefficiency in Medicare and use the savings to cover the cost of prescription drugs not currently covered. Specifically:

• Because Medicare coverage is incomplete, seniors are exposed to thousands of dollars in out-of-pocket costs; separate analysis by the NCPA shows that last year 360,000 Medicare beneficiaries faced costs in excess of $5,000.

• To avoid the prospects of financial devastation, a majority of seniors acquire private insurance to fill the gaps in Medicare—either through a former employer (33 percent) or by purchasing supplemental "Medigap" insurance (36 percent).

• However, economic studies show that seniors with Medigap insurance consume significantly more health care than those without the insurance; moreover, much of the extra care is wasteful and arises because when patients have first-dollar coverage they are less prudent consumers of care.

• In addition, most Medigap policies do not cover drugs and many employer plans have incomplete coverage; as a result, patients and their doctors have a perverse incentive to use doctor and hospital services when less expensive drug therapy would have been preferable.

• A private plan can potentially eliminate much of this waste by providing a unified set of benefits with the same health care dollars.

Currently, the 17 percent of Medicare beneficiaries who are enrolled in a private HMO are enjoying more benefits at a lower cost. However, because the government's method of paying premiums to these private plans is highly imperfect, discrepancies exist. The average HMO is probably overpaid. However, a number have been underpaid—and those are the ones that are leaving the market.

The NCPA study assumes that if seniors leave Medicare and join a private plan, the plan will receive from Medicare a sum equal to the amount Medicare would have spent. Thus, private contracting occurs under conditions that promise no profit and no loss for the government. The study concludes that:

• Upon receiving an amount of money equal to the expected amount Medicare would have spent on each senior plus an amount slightly above what seniors currently spend on Medigap insurance, an HMO should be able to provide comprehensive coverage, including coverage for prescription drugs.

• Seniors who want to exercise more choices should be able to enroll in a fee-for-service plan with a high deductible and a Medical Savings Account—in many cases for a premium that is considerably less than what they currently pay for Medigap. The out-of-pocket cost under these plans would vary, depending on the degree of managed care, and would average about $1,200 a year—far less than the unlimited exposure most seniors now face for the potential cost of drugs.

• In many cases, moving to a private plan would not only provide coverage for prescription drugs, but would also generate considerable financial savings; for example, the average senior who currently has Medigap insurance would save more than $1,000 a year in lower premiums and out-of-pocket costs.

SOME REPRESENTATIVE CASES

The following are representative cases for seniors with different types of insurance coverage under the current system. In all cases, the senior is assumed to continue paying the Part B Medicare premium to the government. The results summarized are depicted in the table that follows the discussion.

Case 1: A Senior With No Supplemental Coverage.—This includes those without any Medigap insurance, employer-provided insurance, risk contract, Medicaid coverage or direct subsidy from the government. Given private alternatives, we assume that this senior will buy a $3,000 deductible plan with no coinsurance above the deductible and moderate to aggressive managed care. That is, we assume that these people will tend to buy the lowest cost coverage available. The MSA deposit in this case is about $600. The result:

• For no additional premium, the senior now has catastrophic coverage for prescription drugs.

• The senior's expected annual personal costs are now substantially lower, leading to expected savings of more than $1,000 per year.

• The senior's out-of-pocket costs are now limited to $2,400 per year, compared to an almost unlimited exposure under Medicare.

Case 2: A Senior With Supplemental "Medigap" Coverage.—We have assumed these people own the Medicare policy Plan F, which does not cover prescription drugs. Given private alternatives, we believe they will tend to buy primarily middle and higher cost coverage. Thus, we have assumed the average premium will be the midpoint of plans with no managed care and low to moderate managed care. The deductible is $3,000 with no coinsurance above the deductible and the additional average premium for this coverage (beyond money provided by Medicare) is slightly more than $200 per year. The average out-of-pocket expense for the new plan is estimated to be roughly $1,500, compared to the average out-of-pocket expense with Medigap plans of slightly under $1,200. The result:

- For a private plan premium that is only a fraction of what the senior currently pays, the private plan can provide catastrophic coverage for all medical expenses.
- The expected savings to the enrollee are more than $1,000 per year.
- If the senior takes the amount he or she was spending on Medigap insurance plus the average annual out-of-pocket expense and subtracts the premium for the new plan, the remainder will equal $2,546; if this amount is deposited in an MSA account, the maximum annual exposure will be $454—compared to unlimited exposure for potential drug costs under the current system.

Case 3: A Senior With Employer-Provided Supplemental Coverage.—This coverage is provided by an employer to cover benefits not covered by Medicare. These plans can vary dramatically, but on average we have assumed that today's coverage is consistent with medigap Plan F—paying all copayments and deductibles for physicians' fees and hospital expenses—and also paying 50 percent of all costs of prescription drugs. Under the private program, we have assumed that the employer can become the "risk contractor," supplying full coverage, or that the employee can apply the employer's expected cost to some other private plan. We assume that the new private plan will be pure fee-for-service with no managed care plan. The deductible in this case will be $3,000 with no coinsurance above the deductible and the additional average premium for this coverage is expected to be roughly $500. Results:

- Whereas the senior previously faced unlimited exposure for one-half of potential drug costs, there is now catastrophic coverage for all health care costs.
- Even though the senior obtains additional coverage, there is actually a small reduction in additional expected costs.
- If the senior takes the amount that was being spent on the employer plan plus the average annual out-of-pocket expense and subtracts the premium for the new plan, the remainder will equal $1,552; if this amount is deposited in an MSA account, the maximum annual exposure will be $1,448—compared to unlimited exposure for one-half of potential drug costs under the current system.

Case 4: A Senior Enrolled In A "Risk Contract" HMO.—These are plans that individuals may choose instead of coverage through traditional Medicare. Currently, the government's payment to the HMO is equal to 93.2 percent of the Medicare Aged Adjusted Per Capita Cost. (Despite this discount, we estimate that the average HMO is overpaid.) The payment to a new HMO covering prescription drug costs is assumed to be consistent with that for HMO Risk Contracts in the market today, or roughly $5,500. The following table assumes that Medicare continues to overpay the private plan. However, to be consistent with the other cases and to achieve a no profit, no loss effect on Medicare, we would need to reduce the payment (and increase the seniors' premium) by about $400 per year. The results:

- For only $153 additional expected cost, seniors can have comprehensive coverage for prescription drugs.
- The tradeoff: seniors must accept small copayments (say $10 for a doctor's visit, $10 to $15 to fill a prescription, etc.) in order to discourage abuse, typical limits on mental health benefits and a $50 copay for emergency room care.
- However, for a small increase in expected expense ($153), seniors will have traded away unlimited exposure to potential out-of-pocket drug costs.

TABLE 1.—Opportunity to Obtain Prescription Drug Coverage: Comparison of Average Costs for All Health Care Expenses for Seniors with Different Kinds of Coverage Today

	Current Coverage			
	No Supplemental Coverage	Medigap Coverage	Employer Coverage	"Risk* Contract" HMO
Senior Costs Today:				
Average Out-of-Pocket Expense	$1,406	$1,161	$667	$866
Private Plan Premium	0	1,611	1,370	150

TABLE 1.—Opportunity to Obtain Prescription Drug Coverage: Comparison of Average Costs for All Health Care Expenses for Seniors with Different Kinds of Coverage Today—Continued

	Current Coverage			
	No Supplemental Coverage	Medigap Coverage	Employer Coverage	"Risk* Contract" HMO
Total Cost Today	$1,406	$2,772	$2,037	$1,016
Senior Cost Under A Private Plan that Covers Prescription Drugs:				
Average Out-of-Pocket Expense (net of any MSA deposit)	218	1,489	1,475	503
Private Plan Premium	$0	$226	$485	$666
Total Cost With Private Plan	$218	$1,715	$1,960	$1,169
Savings With Private Plan (Private Plan Cost Minus Today Cost)	$1,188	$1,057	$77	−$153

*Assumes the voucher equals the same amount paid to HMO risk contractors today. However, to be consistent with the other three columns and to achieve a no-profit, no-loss outcome to Medicare, both the risk contract amount and the voucher need to be reduced (and senior premiums increased) by about $400 per year.

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