

MEDICARE'S FINANCIAL CRISIS

HEARING

BEFORE THE

JOINT ECONOMIC COMMITTEE CONGRESS OF THE UNITED STATES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

APRIL 10, 2003

Printed for the use of the Joint Economic Committee



U.S. GOVERNMENT PRINTING OFFICE

89-222 PDF

WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
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MEDICARE'S FINANCIAL CRISIS

THURSDAY, APRIL 10, 2003

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to notice, at 10:30 a.m. in room 562, Dirksen Senate Office Building, the Honorable Robert F. Bennett, Chairman of the Committee, presiding.

Present: Senators Bennett, Reed; Representative Stark.

Staff Present: Donald Marron, Michael O'Grady, Dianne Preece, Wendell Primus, John McInerney.

OPENING STATEMENT OF SENATOR ROBERT F. BENNETT, CHAIRMAN

Senator Bennett. The Committee will come to order. I extend a good morning to all and welcome you to today's hearing on the challenges facing Medicare.

I know the focus is on Iraq and what's going on there. That is a serious problem and a serious challenge, but long-term.

Medicare may be a more serious problem for this Country.

As I've said before, Medicare is the best Blue Cross-Blue Shield fee-for-service indemnity plan of the 1960s frozen in time. Before we get carried away with rhetoric about what we have to protect and not protect about Medicare, let's understand that simple truth. We don't practice medicine the way we did in the 1960s. And we should not deliver and finance medicine in the same way today.

Protecting Medicare can become a dead-end for us if we insist in preserving Medicare in its 1960s incarnation. Congress must face the fact that Medicare is 40 years old, whereas the practice of medicine is changing so constantly that we could say for rhetorical flourish that it's only 40 months old. Applying another Band-Aid to Medicare would be malpractice. Radical surgery is what is needed.

Exhibit 1 in the case for radical reform is Medicare's growing financial crisis. The promised benefits now exceed Medicare's financial resources by more than \$13 trillion. In other words, Medicare's unfunded liabilities are more than three-and-a-half times as large as our Nation's public debt. This imbalance will only worsen if Congress adds a prescription drug benefit to Medicare.

We have a big problem, one that gets worse every day. To bring Medicare into long-term fiscal balance today would require either an 83 percent increase in the Medicare payroll tax or a 42 percent reduction in Medicare spending. If we wait, these changes would have to be even larger. Enormous burdens on Medicare beneficiaries and on taxpayers thus appear almost inevitable.

We need better solutions. We need creative ideas about how to deliver quality care to a growing population at a lower cost. We need, in short, to start over with a clean sheet of paper. We need to ask ourselves: "Given everything we know today, what's the best way to structure Medicare and, indeed, our entire health-care system?"

Any successful reform must begin with respect for the power of the market. Consumer choice, consumer responsibility, and market competition have long driven the success of the U.S. economy. And the same forces should be harnessed to deliver health care.

Properly structured, market-oriented reforms can deliver quality health care efficiently and fairly. Market forces will increase beneficiary choice, slow the growth of beneficiary and taxpayer spending, and provide incentives for health plans, both public and private, to provide the highest quality health care.

Congress should take care to safeguard vulnerable beneficiaries from any unintended consequences of market forces. However, it would be foolhardy to walk away from all the benefits of market forces for fear of these unintended consequences.

We have a problem and it's not going to go away. Indeed, it seems likely to get worse, given the strong desire to add a prescription drug benefit. I share that desire. Prescription drugs are essential to the health of our retirees. But as we design that new benefit, we should keep in mind that, as noted in the new Committee report released this morning, more than three-quarters of Medicare beneficiaries already have some sort of drug coverage. Any move to add a drug benefit must carefully balance the needs of the beneficiaries with their current sources of coverage—and the financial burdens on taxpayers.

We certainly do need a prescription drug benefit. Prescription drugs do things now that were unimaginable in the 1960s. But we shouldn't paste that benefit into a broken system. We shouldn't create a new set of forms and eligibilities that torment patients, frustrate doctors, and reward those skilled in the black art of Medicare payment formulas. Let us as a Congress face the fact that we need to start from a clean sheet of paper, all over again, with all of the money we are putting into it and say, "Let's create a whole new system that really works."

With that, I welcome the Ranking Member, Mr. Stark, for any opening comment that he might have.

[The prepared statement of Senator Robert F. Bennett appears in the Submissions for the Record on page 39.]

**OPENING STATEMENT OF REPRESENTATIVE PETE STARK,
RANKING MINORITY MEMBER**

Representative Stark. Thank you, Chairman Bennett, for holding this hearing. I welcome our witnesses.

I had the distinct pleasure of seeing Director Holtz-Eakin and Mr. Walker yesterday. And I'm happy to see them again today and hear how they respond to the Chairman's spin on the problems with Medicare.

The title of this hearing, "Medicare's Financial Crisis," is intended, I believe, by the Republicans to be a leading suggestion that Medicare isn't viable and is in a horrible financial situation.

Thankfully the facts point out a much different picture. This is more about ideology of the Republicans than the reality of Medicare's current standing.

Medicare's solvency is at the second highest point of the program's history. I just point this out—that the Republican attack on Medicare's viability is a scare tactic to enable them to achieve their real goal, which is as the Chairman just suggested, dismantling Medicare as an entitlement program that provides benefits at guaranteed prices.

Medicare is better than private plans at controlling costs as we'll hear later from Marilyn Moon, who will highlight her study that Medicare has consistently done a better job at controlling health-care cost than the private sector. I'll leave it to her to discuss that analysis in greater detail.

The major problem facing Medicare's future is basically us. Will we in Congress be willing to make the changes necessary to insure its viability for the future?

The most important change we could make is to add a Medicare drug benefit. Of course, adding that drug benefit will require increased spending. The President and the Republicans don't seem to question increased spending when it comes to tax cuts for the wealthy, doing away with the inheritance tax, which will only help the Chairman's children and mine, but certainly won't help most lower income seniors or children who have to make it on the own.

When it comes to a Medicare drug benefit, the response is always: "Oh, it's too costly to do a real benefit."

We Democrats don't think that's the case. Republicans would argue that a Medicare drug benefit can't be added unless substantial "reform" is attached.

Well, I'd like to research a little what you really mean by reform. Do you mean something like the President's outline of a plan that would force seniors to enroll in private managed-care plans in order to receive decent prescription drug coverage, while those in traditional Medicare would receive minimal drug coverage and some Mickey Mouse discount cards?

The Faustian bargain presented to seniors is to receive the drugs they need in exchange for giving up comprehensive health coverage with their choice of doctors. And that's not a fair choice—and not one that any Member of Congress is forced to make. Seniors shouldn't have to make that choice either.

The GAO estimates show that foregoing additional tax cuts beyond current law would provide an additional 25-year window for Medicare solvency while we consider how to slow health-care costs. At a minimum, this should be done.

Dr. Holtz-Eakin has referred to the Medicare Trust Funds as merely "bookkeeping devices" used by the Treasury. I'd submit to you that a Trust Fund is more than that. It's a promise.

It's a promise that we made to 40 million elderly and disabled Americans that they will receive quality health care and that Medicare will be there for people who need it, in every hamlet and every corner of this country, so long as the House and the Senate here in Washington are willing to keep that promise.

It's up to the Republican leadership that controls the House and the Senate to keep or break this country's promise to our seniors. That's what's before us.

We had Dr. Uwe Reinhardt with us yesterday. Mr. Chairman, he did "A Primer for Journalists on Medicare Reform Proposals," I ask unanimous consent it be made a part of this record. As for—objection, I'll put a Committee insert.

[The primer entitled "A Primer for Journalists on Medicare Reform Proposals," by Dr. Reinhardt appears in the Submissions for the Record on page 124.]

It was Dr. Reinhardt who challenged us in Congress. He says the critics of Medicare, chiefly market-oriented policy analysts and policymakers, will call the program outdated. He suggests that the President has suggested the same thing.

But the gaps in coverage are our fault. We're the ones who could provide the coverage—and we must. The failure to modernize Medicare is up to us, always Medicare has been a world leader in innovation in many areas and it doesn't get credit for that. It's the most efficient bill-paying operation in the United States. It offers the penultimate choice in services.

And so, if there's a shortcoming, it's ours. We talk about choice and competition. And I know the Chairman is an expert in this and understands the value of entrepreneurial creativity. But you can't have it in health care and in Medicare.

First of all, none of us know—you or I—with any certainty as to what medical treatments they would give to us, how much they cost, what they are.

A doctor asks us to take a test and we take it and we hope we pass. And we don't know what it costs and usually neither does the doctor.

That's no way to have a market. If I'm going to decide whether to buy your calendar, I can price it against the lesser quality brands and understand that I buy a high-quality product from you. But I can understand it.

I can get you 12 months, 52 weeks—that I can handle with my shoes and socks on. But he wants to talk to me about various chemotherapies, I don't know. I trust the Chairman probably doesn't know and our witnesses don't know.

So I don't know how we could be expected in the vernacular of buying an automobile or commercial product to have a "free market" when we are incapable of understanding what it is we're buying.

Also, we can't have a fair competition, because if you are the organization Blue Cross, you can pull out of some town in Utah if you choose not to serve there. Medicare can't. Medicare and Medicaid must serve every hamlet in the country. We don't have the luxury that private plans have to pull out of an area that they may not choose to serve.

So there are all those impediments to what we think of as the standard "competitive model" to provide this. And I think we have a plan that is arguably the most popular government plan in the country today. And I would challenge my colleagues, not our witnesses and not the bureaucracy, to say: Let's do our job. We're the

board of directors of Medicare. CMS is the executive cadre who should carry out the principles we give them.

Let's go back to work. Let's get the Senate Finance Committee and the House Ways and Means Committee to do their job. Then I think we'll continue to have a program that we'll be proud of.

[The prepared statement of Representative Stark appears in the Submissions for the Record on page 40.]

Senator Bennett. Thank you. And thank you, Mr. Stark. We could engage this debate among ourselves, but we won't. We'll go to the witnesses.

But I can't resist responding one little bit. If I sit on the board of this particular enterprise, I have received more criticism from the customers about this enterprise than anything else that I sit on the board of.

So if it's doing so well, at least those people who have my home phone number haven't discovered that yet. And they are complaining bitterly about a number of things.

With that, we will stop debating amongst ourselves.

Mr. English, if we can, I would like to go directly to the witnesses. Then we will go through the round of questioning. But we appreciate your being here.

Our first panel we have David Walker, Comptroller General of the United States; and Douglas Holtz-Eakin, the new Director of the Congressional Budget Office, both of whom have examined this issue in considerable detail.

Gentlemen, we appreciate your being here and look forward to your testimony.

Mr. Walker, we'll start with you since seniority-wise you've been in government service a little longer. But that means we give the CBO the last word. So you can each take some comfort in the order I've chosen.

**OPENING STATEMENT OF HON. DAVID M. WALKER,
COMPTROLLER GENERAL, GENERAL ACCOUNTING OFFICE**

Mr. Walker. Somehow, Mr. Chairman, I think you are going to have the last word. But thank you very much. It's a pleasure to be here, Mr. Chairman, Ranking Member Stark, Mr. English, and other Members of the Committee, to testify with regard to an issue of long-standing interest to myself. That is Medicare.

As you know, Mr. Chairman, I have been involved in this issue for many years including serving as a public trustee of both Social Security and Medicare from 1990 to 1995. So this is not a recent interest. It's one of long standing.

I recognize the importance of this program to the American people. Over 10 years ago, the public Trustees of Social Security and Medicare, including myself, stated that the Medicare program was unsustainable in its present form.

Since that point in time, others have come to the same conclusion. The Congressional Budget Office (CBO), The Office of Management and Budget (OMB), and others have come to that same conclusion.

The recent Trustees' report shows that Medicare's projected financial condition has worsened substantially in the last year. The actual or present value of the deficit has increased approximately

20 percent to \$6.2 trillion for HI alone, which is Medicare Part A. That does not include SMI or Part B.

Regarding Trust Fund solvency—it's true, the Trust Fund is projected to be solvent under the intermediate assumptions until 2026. And there are considerable assets in the Trust Fund in the form of non-readily marketable government securities that are backed by the full faith and credit of the United States Government. And I think it's important that this be stated.

These bonds do have legal significance. They do have moral significance. They represent a priority claim on future general revenues. They do not, however, have any economic significance. This is part of why Trust Fund solvency can be misleading.

I have been a trustee in a number of other capacities, including dealing with pension funds and health funds in the private sector. The Trust Funds that we have in the Federal Government, including those for Social Security and Medicare, are accounting devices.

They are not Trust Funds as defined in Webster's dictionary. They do not have the same fiduciary responsibilities associated with them. And I think we need to recognize that reality.

In the year 2013, the HI program will start experiencing a negative cash-flow, at which point in time these closely held government securities, which are of value, will have to be redeemed.

But in order to redeem those securities, we'll have to increase taxes and/or cut spending and/or increase the debt held by the public. If we choose the borrowing approach, the deficit will grow dramatically.

In the first chart [see figure 1], which I have up here, my colleague is helping me to show how the cash-flow deficits escalate dramatically. And this is in 2003 constant dollars, so inflation has been taken out.

Cash is key and it's important to keep in mind. We also need to note that if we look at entitlement spending as a percentage of the economy, it is continuing to grow. There's been a significant increase in mandatory spending over the last 40 years.

As you know, in 1962 when John F. Kennedy was President, the Congress got to decide where almost two-thirds of the Federal budget was going to be spent every year.

Now it's almost reversed. Congress gets to decide a little over one-third of the Federal budget every year. And the growth in Social Security, Medicare, Medicaid [see figure 2] and interest on the Federal debt is continuing.

At the same time, what helped finance the increase in those programs over the past 40 years were reductions in spending for national defense, from 50 percent of the Federal budget in 1962 to 17 percent in 2002 is not likely to continue in the future.

We know that there will be additional spending for national defense and now homeland security. So as a result, if we look forward to the future, based upon the Government Accounting Office's (GAO) latest long-range budget simulation, which is updated twice every year, you can see that we are headed for a troubling future—namely, that there is a significant and growing mismatch [see figure 3] between projected revenues and projected expenditures.

This simulation assumes that the Social Security and Medicare Trustees are correct in their intermediate best estimate assump-

tions; it also assumes that discretionary spending grows by the rate of the economy, and that the 2001 tax cuts continue out into the future. Yes, it would help if there were additional revenues. But I will tell you that even if the tax cuts are allowed to expire, which is current law, there is still a significant gap. The gap is so great that we are not going to grow our way out of the problem.

Tough choices will be required—and in fairness, not just from Medicare, but also from Social Security, discretionary spending, and tax policy, including tax incentives in particular. We're going to have to make some tough choices.

I should say, Mr. Chairman, you're going to have to make some tough choices to try to decide what's the proper role of the Federal Government in the 21st century. How should it do business? What are the priorities? How are you going to allocate limited resources to have the most positive effect over time? And hopefully, Mr. Stark, yes, deliver on whatever promises are being made.

I think the problem right now is there's a big gap between promised benefits and funded benefits. There's a huge expectation gap in the public. I think we have a responsibility to close that gap in a way that's both fiscally responsible and sustainable over time.

As you mentioned, Mr. Chairman, there's increasing interest in modernizing Medicare's benefit structure. I think there is no question that if Medicare was designed and implemented today, it would include a prescription drug benefit. There's clearly a need for a prescription drug benefit.

However, Medicare also needs to be modernized in many other ways because many other things have changed since 1965 when Medicare was created.

I think it would be prudent for Congress to consider targeting any prescription drug benefit and including appropriate cost-containment mechanisms and other programmatic reforms that would hopefully not worsen Medicare's already deteriorating long-range financial condition.

I say it would be prudent. It's obviously not required. Ultimately elected officials will make that choice.

It would be nice for us to have a Medicare Hippocratic oath. Let's don't make the long-term problem even worse.

That will be tough. But ultimately, we're going to have to come to grips with this issue.

Last, let me say that I think that in reality we have three sustainability problems. One deals with the Medicare program. These [see figure 4] long-range imbalances only deal with HI. They don't include SMI.

By the way, this shows how Social Security, Medicare, and Medicaid is going to increase as a percentage of the overall economy, which is also important.

One is Medicare, HI, and SMI. The second is health care. We've got a broader health-care challenge and a sustainability problem there as well.

Third, we've got an overall Federal fiscal imbalance challenge. Many of these are interrelated. We ultimately have to try to come to solutions that will address all three.

In that regard, GAO is preparing a briefing document that should be available within the next month or so to provide informa-

tion to the Congress and other interested parties on some key trends and statistics. This document will include a series of questions that Congress may wish to consider when analyzing various health care reform proposals.

We've already done this for Social Security. It's been embraced by the Congress. We've used it to analyze various Social Security reform proposals at the request of the Congress.

By the way, this analysis will not just ask questions on cost, which is important. It will also ask questions on access, quality, administrative matters, and other issues in order to try to come up with a balanced perspective so that the Congress can hopefully make more timely and informed judgments.

Thank you, Mr. Chairman. I look forward to answering questions after my colleague has had a chance to give his statement.

[The prepared statement and charts of Mr. David M. Walker appear in the Submissions for the Record on page 42.]

**OPENING STATEMENT OF DOUGLAS HOLTZ-EAKIN, DIRECTOR,
CONGRESSIONAL BUDGET OFFICE**

Dr. Holtz-Eakin. Thank you very much. Let me touch on some of the subjects in my testimony and what the implications are for the policy going forward.

As highlighted by my colleague, under current law and without any additional benefits such as a prescription drug benefit, Medicare spending is on a course to rise dramatically as a fraction of our national economy, as a fraction of the Federal budget.

As shown in the chart [Figure 1 in the prepared statement], Medicare spending currently constitutes 2.5 percent of Gross Domestic Product (GDP). Over the next several years it will rise to something like 9.2 percent of GDP, or roughly half the size of the current Federal Government in our economy.

It's commonly assumed that this is all due to the aging of the U.S. population—the retirement of the Baby Boomers and the subsequent shift in the ratio of retirees to workers in the economy.

As shown in the chart, the top portion, the lighter gray portion, is indeed the effect of an aging population. But that constitutes only 30 percent of the rise in Medicare spending as a fraction of our economy. The remaining 70 percent is due to the fact that medical costs in our economy are rising faster than GDP.

As shown in the chart, we assume there will be an excess cost growth of 1 percentage point over the forecast horizon. That pace is indeed a bit slower than over the history of Medicare, where spending has averaged 2.8 percent faster than the growth rate of GDP over the period from 1970 to the present.

With that in mind, let me review the current trends in cost growth as we see them.

The Congressional Budget Office has recently updated its baseline projections for Medicare spending. Over the next 10 years, we continue to see Medicare costs growing 6.8 percent per year faster than the rate of GDP growth in the economy.

And if one looks at the growth rate of prescription drug spending by the Medicare population, that rate is projected to rise by 9 percentage points per year—again, considerably faster than the rate of GDP growth.

Putting those facts together suggests the need for thinking about policy in the years to come. At the broadest level, decisionmakers are faced with the following rough tradeoffs.

One possibility would simply be to continue the tradition of having the government remain at roughly 18 percent of the size of the economy. That's the ratio of Federal receipts to GDP in the post-war period, roughly speaking.

If so, the rise in Medicare spending and the simultaneous rise in Social Security and Medicaid outlays are currently on track to equal about 20 percent of GDP over this horizon. Constraining the Federal budget to the traditional level of Federal Government involvement in the economy would require severe tradeoffs within the budget to say the least.

An alternative would be to decide to have a government that is larger than has been traditionally the case in the scope of the economy. If that option was chosen, it would require higher taxes.

As an illustration of the magnitudes involved, if one were today to raise the fraction of Medicare spending from 2.5 percent to 9.2 percent—if that were to happen instantaneously instead of over 75 years—it would require doubling the current payroll tax—the total payroll tax from its current level of about 15 percent.

The cost implications of that are now clear. Another alternative would be to hope that the economy would grow faster and as a result enlarge the economic pie from which all resources—the public sector, Medicare, Social Security, and others as well as the private sector—would draw.

Within Medicare, as my testimony outlines, I think, there are no easy fixes. Among the potential policies we contemplated and displayed in our budget options document are raising the normal retirement age from 65 up to 70, instead of just up to 67. Doing so eliminates 7/10 of 1 percent of the increase in Medicare as a fraction of GDP over the 75 year period, which is a small fraction of the overall rise that is projected in these simulations.

Alternatively, one might double the premiums paid by beneficiaries, under Supplemental Medical Insurance [part B of Medicare] from 25 percent to 50 percent—that is, double the required contribution. Even that large a policy change affects only 1 percentage point of this overall growth.

And so under current law, there are no easy fixes that the Congress may contemplate. Instead, as my colleague pointed out, a much harder set of choices confronts us.

My closing remark would be that it may be the case that this Nation will choose to spend more of its increasing wealth on medical expenses and Medicare in particular.

If so, it's still useful to keep an eye on using those Federal dollars wisely to empower beneficiaries through the incentives and the availability of options to control their Federal dollars and use them wisely and get the highest quality per dollar of Federal expenditure in Medicare as we go forward.

With those remarks, I'll be happy to answer your questions.

[The prepared statement of Dr. Holtz-Eakin appears in Submissions for the Record on page 69.]

Senator Bennett. Thank you very much. I think this economic analysis is very helpful and it's chilling. But there are some assumptions built into it that I'd like to explore with you.

The assumptions, Mr. Walker, if I could go back to your statement, are that this is Medicare in its present form.

Mr. Walker. That's correct.

Senator Bennett. If we look at the role of prescription drugs for just a minute, prescriptions save health costs. That is, you take a pill now for something you used to go into the hospital to have an operation for. There is an efficiency that takes place. And Medicare, as currently structured, does not recognize that efficiency—indeed, it penalizes it because, as I say, it's the 1960s program and therefore the benefits system that it reimburses was drawn up in the 1960s and has been perpetuated ever since.

It's kind of like the Endangered Species Act. Things are on it, but when things get better, nothing ever comes off. They just keep adding to the list, but they never take anything off when they solve a problem.

And a careful look at Medicare would say there may be some things that are inappropriate to reimburse at 1960s levels because they can be solved with a different kind of treatment—again, specifically, prescription drugs.

There are plenty of examples of this. There are also examples of screening programs, which are not covered, which, if they were done would produce overall lower costs. The complaints get—back to my offhand comment to Mr. Stark—the complaints I get continually are that Medicare drives us to bad medical practice.

Things are being done in order to skew them in a way that will produce Medicare reimbursement which, if they were done in an unfettered atmosphere, where the best product or the best result was taken into consideration, would be done very differently.

But they are not done that way because Medicare won't reimburse them if they are done that way. We are turning doctors into liars so that they can somehow deliver what the patient needs and still get some Medicare benefit for it.

Now, Mr. Walker, it's not necessarily in GAO's purview, but since we're talking about a clean sheet of paper here—at least I'm talking about a clean sheet of paper—is the GAO equipped to do any kind of study on this issue of how Medicare by the payment system that it's structured is distorting the provision of health care and thereby, in fact, driving up costs? Or is that something that's not really appropriate for a group of auditors?

Mr. Walker. As you know, less than 15 percent of what GAO does has to do with financial management. Eight-five percent-plus has to do with program reviews, policy analyses, investigations, legal adjudications and other types of professional services. This is something that I think we could do possibly in conjunction with the national academies.

We are forming partnerships quite frequently with a variety of organizations, including strengthening our partnership with the national academies.

I do think there's some truth to what you're saying, not only with regard to Medicare, but frankly, with regard to the entire Federal budget. We tend to assume that the base is OK and all we're doing

is just adding on to what we already have rather than fundamentally reviewing and re-examining what we should be doing.

I think there is a need for that fundamental review and re-examination and we'd be happy to try to help, but we'll have to talk with you separately about the nature, timing, scope, et cetera.

Senator Bennett. That's one of the advantages of the Joint Economic Committee, as Alan Greenspan pointed out to me when I became Chairman, is that we have no legislative responsibilities. Therefore, we are released maybe from the kinds of constraints that do hit the Ways and Means Committee and the Finance Committee, in that we can look—to use the vastly overused cliché—we can look outside the box. We can look at new things that maybe legislative committees don't feel free to look at.

And given the enormity of this challenge that has been presented both by your charts, Mr. Walker, and your charts, Dr. Holtz-Eakin, we've got to think differently than we have ever thought before. And we've got to look for new solutions in ways we've never looked at before.

So I'd like to pursue that. I have a number of other questions. But in respect to my colleagues, we'll now go through the established round.

Mr. Stark, we'll hear from you.

Representative Stark. Thank you, Mr. Chairman.

As I say, I've heard this testimony before. We're basically facing here part of a "chicken little" scenario. We've got these two distinguished experts representing the throes of Medicare, trying to gin up a crisis where basically, none exists, while we are looking here at protections that offer up predictions that are notoriously inaccurate and probably would not serve, certainly in any enterprise that I can think of.

Now, for example, Mr. Walker, how many times has Medicare reached the 75-year actuarial solvency test?

Mr. Walker. It never has to my knowledge.

Representative Stark. That's right. This year, not the best year, at least one of the two best years Medicare has had in terms of solvency since its inception.

Mr. Walker. If you look solely at the amount of assets in the Trust Fund, then that's a true statement. But I believe that is misleading.

Representative Stark. I don't believe it's as misleading as what you're doing. The chart that you had I thought was prepared by Arthur Anderson, who I thought was out of business.

But the facts are Mitch Daniels suggested that when you move to 10 years, as he said, it's led to a lot of nonproductive and counterproductive, to base Medicare solvency on the data, that prove flawed, but wildly misleading.

And to the CBO's record in projecting Medicare, Dr. Holtz-Eakin is equally miserable. If you look at CBO's record, when you project Medicare 5 years into the future, it overestimated Medicare costs in every year since 1985. For example, in 1985, CBO projected that Medicare spending in 2000 would be fully one-third higher than it actually is.

Now, part of the reason for the reduction is the Balanced Budget Act. But that's the point. It is absolutely asinine to assume that the

Congress that follows on after we're gone is going to allow Medicare to go broke or default on any government securities, which ought to dispel this mania for cash accounting that Mr. Walker has to deal with.

When we talk about forecasts, let's talk about the President's tax cut. The present value over 75 years is between \$12 and \$14 trillion as opposed to a \$6 trillion deficit in the Medicare Trust Fund. The Social Security deficit is only \$3.8 trillion, as opposed to these irresponsible tax cuts.

So I think you have to get this thing into focus. As I say, if what you're trying to do is scare the seniors in this country, that's fine.

If you're trying to think rationally and reasonably about what we might do to improve Medicare, there are a host of things before us. We could, in fact, bring the benefits into the 21st century before it's over.

That, I would suggest, portends that we deal with prescription drugs. We probably ought to look at—although it would be very expensive, but it's probably a candidate for good social insurances as is Medicare—to look at long-term care. I don't know if the States can sustain that much longer.

We certainly—although we have judiciously stayed out of physicians' practice except as a secondary or a tertiary effect of what price setting that we have done—we have directed physicians on how to practice.

But as you look at the Dartmouth studies that show that in the Sunbelt, in Florida, Louisiana, and places like that, and in California, we are spending five or six times as much for the same population and the same procedures that we spend in Minnesota or in North Dakota.

It's equally good medicine. You'd go a long way to say that the Mayo Clinic is any better or any worse than some hospital in Texas or Louisiana, yet they are doing things for far less.

That happens to be practice habits. It has nothing to do with our payment structure. It is the way, I guess, people were trained to do medicine.

But it would seem to me that it would be worth our looking into those types of things, because if we were paying for medical care across the country at the same rate that it costs in Minnesota, Medicare would be solvent for centuries.

Now, it's still controlled. And this is the only way you will do it—is to purchase more economically, or to begin to see if the medical profession would join with us in coming to some kind of going to the least expensive practice.

Thank you, Mr. Chairman.

Mr. Walker. Mr. Chairman, can I respond really quickly? Because something was said that really disturbs me.

Mr. Chairman, for the record, I was a Trustee of Social Security and Medicare from 1990 to 1995. I resent the fact that anybody would suggest that I'm here to destroy Medicare. I care very much about that program.

Number one, Medicare will continue to exist. There's no question about that. Even when the "Trust Fund" goes insolvent, there will still be revenues. That's not a question.

So there's no way that Medicare is going to go away. But I think we have to recognize reality. Are we going to play lemmings where we are going to wait until we hit the cliff and fall off the cliff? Or are we going to plan ahead?

There is a \$6.2 trillion discounted present value unfunded gap between what's been promised right now and the current revenue stream. Congress may decide to fill it with taxes, to raise taxes.

That's your choice, but there's a \$6.2 trillion gap that increased 20 percent last year and is likely to increase in future years. The Trustees have generally underestimated the cost growth, not over-estimated the cost growth.

And, furthermore, Congress does not have a very good track record of dealing with this type of future problem. Most of the things that Congress is talking about doing now are going to make things worse, not better.

We face a demographic tidal wave the likes of which this country has never seen. We have 10-year cash-flow budget projections that end in 10 years. But, you know what? The world is not going to end in 10 years. So I think it's important, and I'm just trying to state some facts. There are differences of opinion within Congress, but ultimately Congress has to decide how to resolve it.

But I can say for myself, there's no way I'm talking about trying to destroy the Medicare system. I've got parents, children and grandchildren too.

Senator Bennett. Thank you.

Representative Stark. I would hope you would not be offended if I take your pooh-poohing of these charts and give them to the Democratic Ranking Member of the Senate Budget Committee, who has been using these charts throughout the entire budget debate in an attempt to trash the President's program.

I'm glad to have you say that they're nonsense so that we can get Senator Conrad to stop using them.

Senator Bennett. Mr. English.

Representative English. Thank you, Chairman. I have a number of substantive questions, but if I could, I'd like to apply a flame-thrower to any remaining straw men that have wandered into our vision on this.

Dr. Holtz-Eakin, are you aware of any serious economist who argues that Medicare is not in a long-term crisis?

Dr. Holtz-Eakin. No.

Representative English. Do you know of anyone, Mr. Walker, who has made that argument credibly?

Mr. Walker. No, I don't. I also don't know of any economist that says that these bonds have economic substance.

Representative English. Very good. Finally, and I think we can dispose of this quickly, Director Holtz-Eakin, is there any connection between the President's tax cut and the solvency of Medicare?

Dr. Holtz-Eakin. In the end, as the chart was designed to illustrate, there will be demands for different programs, and they will be financed in the way that the Congress chooses.

Representative English. Mr. Walker, anything to add to that?

Mr. Walker. Not directly, but indirectly there's no question you have to look at the revenue side and the spending side. I look at the gap. And obviously, that contributes to the gap.

Representative English. The President's tax cut contributes—

Mr. Walker. To the gap and the overall fiscal imbalance, not directly to Medicare, but to the overall issue.

Representative English. I understand your point, although I think what we're doing a hearing on today is Medicare.

Mr. Walker. That's correct.

Representative English. Getting more to the substantive side of this discussion, Dr. Holtz-Eakin, what is the long-term projection for Medicare as far as what percentage of the total medical expenditures are ultimately going to be within Medicare within this economy?

As there are more people who are utilizing Medicare who make up more and more of the patient population as people live longer, how do you see that trend developing? Both gentlemen.

Dr. Holtz-Eakin. At the moment, the number is a bit above 50 percent. That is, 53 percent of total health spending by the elderly is paid for by Medicare. If you fixed the growth rate of Medicare costs at the rate of private-sector health costs—in the long run, they will end up running very close to each other, as they always have—then the share paid by Medicare (under current law) should remain about half of total health spending by the elderly. What's left is a shift in people across the line from private-sector health into the Medicare program as they age.

From another perspective—how much is Medicare spending as a share of the Nation's total health spending—I don't have the precise number on that, but you can see that you're going to move upwards from today's level of 17 percent.

Representative English. Mr. Walker, would you care to comment?

Mr. Walker. It's likely to increase. I can't give you a percentage. One reason it's likely to increase is because of the demographic trends that Dr. Holtz-Eakin mentioned as well as trends in the private sector.

The fact of the matter is, there's been a significant backing away from providing retiree health insurance by employers. And, furthermore, now many employers are backing away from as generous health plans even with regard to their active workers.

Representative English. Would it be fair to say that there will be some point at which Medicare will represent the predominance of spending within the medical economy without policy changes?

Dr. Holtz-Eakin. It seems a fair guess, yes.

Representative English. How would you characterize the current structure of Medicare in terms of what sorts of procedures it favors and what impact it has on the introduction of new technologies?

Does it encourage the introduction of new technologies, which over time improve health care and ultimately, we would hope reduce, as it has in other economies—reduce costs? Or does it tend to retard the introduction of new technologies?

Dr. Holtz-Eakin. I would say there's no easy characterization of the broad array of different technologies and how Medicare either promotes or discourages their use.

It is a fact that new technologies have been the prime source of rising health care costs in Medicare and elsewhere. It is also true that Medicare is on the whole not yet the dominant driver of new technologies, especially relative to the role of private-sector health care.

Representative English. Would you like to comment, Mr. Walker?

Mr. Walker. I have not seen any evidence to show that it promotes the development of new technologies.

Representative English. What sort of impact does the current design of Medicare services have on the introduction of enhancement of preventive care?

Dr. Holtz-Eakin. We don't really have a bottom line on that, although it's actively under study. It's a great research question that applies to preventive care as well as prescription drugs—whether they will, on balance, lower costs in total.

Representative English. Thank you, Mr. Chairman.

Representative Stark. Quick comment. Medicare right now is about 20 percent of total medical spending in the country according to something or other here—Medpath—if that's helpful.

Dr. Holtz-Eakin. So the record is clear, Medicare correctly accounts for about 17 percent of our Nation's total health spending. I misunderstood the question.

Senator Bennett. Ms. Maloney.

Representative Maloney. Thank you, Mr. Chairman. I thank both of our panelists for your testimony and your public service.

Dr. Holtz-Eakin, I'd like to follow up on my colleague, Mr. English's question. Isn't there a connection between revenues and Medicare? And if we cut revenues, will we not cut our ability to deal with Medicare?

And to get specific about the budgets that are before us, the President's budget asks that the \$1.35 trillion 2001 tax cut be made permanent. At the same time, there is a debate before Congress right now over an additional \$700 billion tax cut over 10 years.

And over 75 years, these tax cuts could account for roughly 2.2 percent of the GDP, enough to wipe out the entire health insurance fund shortfall, which would be roughly 1.1 percent of GDP over 75 years.

In light of demographics that we are facing with the Baby Boomers coming up, do you believe that it's wise policy to make the 2001 tax cut permanent and adding new tax cuts on top of that to those that have already been approved?

Dr. Holtz-Eakin. It's not my role as the CBO Director to make policy recommendations.

The point I was trying to make, in which I think the math is fairly compelling, is that Medicare, Social Security, and Medicaid—if they continue to grow under current law—will become large demands on our economy as a whole.

If the Congress chooses to finance that 9 percent of GDP that Medicare is projected to account for over the long term, such fi-

nancing will require higher taxes or enormous borrowing or both. The math on that is inescapable.

Representative Maloney. Basically what you're saying is that if we lower our revenues, that will definitely increase our long-term deficits. We're now at \$308 billion and galloping forward with deficits. Will that not impair our Medicare obligations?

Dr. Holtz-Eakin. I think it's well within the power of the Congress to choose to continue to finance each dollar of this projected Medicare spending if it chose to raise taxes or borrow more. I would argue that if such spending levels continued, a policy of borrowing the funds would not be sustainable.

Representative Maloney. So it's not sustainable if we continue on the current road we're on, which is cutting revenues, running up deficits?

Dr. Holtz-Eakin. In the absence of other policy changes, this gap will widen to the point where it cannot be financed by borrowing alone.

Representative Maloney. You've also testified that economic growth is the biggest key for long-term health of the Medicare program. In your view, what are the best ways to achieve economic growth?

Dr. Holtz-Eakin. Whether it's the best hope or not, it does raise the chances that the economic pie will be larger and more capable of financing Medicare and all other demands on the economy.

In the end, the degree to which public policies can improve long-term economic growth depends on whether they on balance promote saving at the expense of current consumption.

Economies grow over the long term by accumulating capital, labor and skills, and new technologies. Broadly speaking, that requires sacrificing the use of resources for present consumption in favor of saving for the future.

Representative Maloney. To get back to the specifics, what are the current CBO's long-term economic growth projections factoring in the tax cut? And has the 2001 tax cut affected CBO's long-term economic projections?

Dr. Holtz-Eakin. CBO's most recent economic projections are the January baseline projections, which go out 10 years. In those projections, the broad, underlying long-term growth rate is determined by the rate of growth of the labor force, which is a bit under 1 percent, and the rate of growth of technology and production, which is on the order of 2 percent or so.

So the long-term economic potential growth to the U.S. economy is on the order of 3 percent to 3.2 percent.

Representative Maloney. Do you see the deficit projections harmful to Medicare's stability?

Dr. Holtz-Eakin. There's no automatic link from the difference between receipts and outlays to Medicare's stability. Any particular program within the outlay structure lies within the province of policymakers to finance the total outlays in any way they choose.

Representative Maloney. But we know that we have these deficits and we know that they are projected to grow. Is that going to impact on Medicare's stability?

In other words, where can we find the revenues then for Medicare if we continue to lower revenues and run up the deficit? Where is the money going to come from?

Dr. Holtz-Eakin. That, in the end, will be a decision that the Congress makes. I point out as a matter of record that in CBO's baseline projections and in its analysis of the President's budget, the pattern of deficits is one in which they are not ever increasing.

In fact, under the baseline projections, the unified budget balance moves into surplus in about 2008. And under our analysis of the President's budgetary proposals, the deficit peaks in fiscal year 2004 and then declines thereafter and becomes smaller.

Senator Bennett. Senator Reed.

Senator Reed. Thank you very much, Mr. Chairman. You were talking about the 10-year projections you are doing. I understand you also do simulations that go out much further that underscore these models.

Dr. Holtz-Eakin. Yes.

Senator Reed. In the context of simulation, there's basically two ways we can address this crisis: one, raise revenues; or two, you cut benefits. Is that conceptually fair?

Raising revenues—we used to have a surplus, so we had up until recently the possibility of using surplus funds. That would be a permissible way to provide some relief to Medicare. Is that true?

Dr. Holtz-Eakin. If it were possible to carry those surpluses forward in a meaningful way.

Senator Reed. If we have them, we keep them, and can carry them forward. So I guess that is possible.

But now we're really left with two options to raise revenues then: increase taxes or borrowing. Is that your estimate?

Dr. Holtz-Eakin. The math end is overwhelming. If you're going to spend money, you either raise taxes or borrow.

Senator Reed. In your analysis, do you assume different levels of borrowing and taxation in your analysis which leads you to the question which I don't want to hide: Have you done any sort of analysis at the rate of borrowing that begins to influence interest rates in the contrary?

Dr. Holtz-Eakin. For this analysis, our projections come in two parts: one, our long-term projections for economic growth, which I described in my answer to the Congresswoman; and two, our projections of Medicare spending. We have a combination of demographic components as well as cost increases. Those are outlay streams that represent the burden of that program on the economy. How it is financed is not addressed.

Senator Reed. Like most economies, there's a certain circularity here. If we choose, for example, to finance this deficit with borrowing, I presume that has an impact on interest, which has an impact on economic growth, which goes back to your point. The best way to preserve or grow or save ourselves this problem is economic growth.

Have you done any analysis with respect to that interaction?

Dr. Holtz-Eakin. We have not specifically done an interaction that tries to debt-finance this sort of an outlay stream. I would argue that that alternative does not produce a pattern of public deficit that's sustainable.

To do a simulation that raises the annual deficit to 9 percent of GDP is something CBO has not done.

Senator Reed. Well, no, but the possibility exists from your crisis scenario that if we don't raise taxes dramatically or we don't curtail benefits dramatically, the final option is to borrow the money, which would have a significant impact on interest rates and economic growth. Is that fair?

Dr. Holtz-Eakin. Yes.

Senator Reed. I think the other question I want to raise is many people have proposed different sort of structural approaches to this problem: medical savings accounts, HMOs, Medicare HMOs, et cetera. Do you see those structural approaches as relieving us from this dark choice between raising revenue or cutting benefits?

Dr. Holtz-Eakin. I see those approaches as variations on a theme in which you attempt to provide the incentive and the opportunity for both providers and for beneficiaries to undertake cost controls that they see as in their interests. And even if they do not lower total spending—but they do give greater quality per dollar and make people happier with those Federal dollars—it may be the case that we continue to spend more as a Nation, as I mentioned in my opening remarks.

But the degree to which those dollars are used wisely and satisfy the needs of the ultimate beneficiary, I think, is the question.

And the degree to which alternative institutional arrangements allow that to happen is really, I think, the core question.

Senator Reed. There are some that would suggest that the alternative institutional arrangements don't provide higher quality, in fact, provide higher frustration levels for people who claim they need the service.

They go to their insurer or their health-care provider and find that they can't have it unless they go through 15 different appeals and 16 different—in fact, it adds sort of dead-weight cost to the whole system.

Is that a reality that you've thought about? It would be nice if we could design a system that is absolutely efficient and everybody gets exactly what they need exactly when they need it.

But some of these systems are designed in some respects perhaps simply to deny maybe legitimate costs because that provides benefits to the organization that's controlling the process.

Dr. Holtz-Eakin. In the narrow role of CBO's job in the scoring of bills, we are focused entirely on costs. Your question is about what's the value per cost.

As an economist, I can tell you that the broad lesson, to be honest, is that the more choices individuals have to reveal what they value, the greater the opportunity for them to be satisfied with their experience.

Senator Reed. My time has expired, but the reality that I see in health care, you don't have that many choices. If your employer gives you Blue Cross that's great. But if he doesn't give you Blue Cross, then a lot of times your choices are next to nil.

In the Medicare context at least people do have a guaranteed level of service.

Thank you very much, gentlemen. And I'm sorry I didn't get a chance—I also have to recognize my colleague friend, Sue Urban,

who went to the Kennedy school with me along with her husband. That's why you all sound very bright.

[Laughter.]

Senator Bennett. Thank you very much. I think we've reached the point where we can thank you and dismiss you because the debate is shifting away from the economics and the economic impact of what's happening to the internal kind of thing.

While I'm sure you have a contribution to make here, I think our next panel is probably geared in that direction. So instead of having another round of questioning, we will thank you both and look forward to hearing from you both.

This is obviously not something that's going to go away. And the Congress is going to have to deal with it.

So we'll move to the second panel, where we hope to get further insights on how the Congress might address Medicare's financial challenges as well as some of the service challenges.

We're privileged to have with us three outstanding witnesses: Dr. Gail Wilensky, Senior Fellow at Project HOPE; Director John P. Martin, Director for Employment, Labor, and Social Affairs at the OECD; and Dr. Marilyn Moon, who is the Senior Fellow—or a Senior Fellow—at the Urban Institute.

Dr. Wilensky, we will start with you.

[Pause.]

I should point out that Dr. Wilensky is a former administrator of the Medicare program. That's why we're starting with her.

With that level of expertise you may not want to admit that credential by the time the questioning is through. But we do appreciate your willingness to appear.

**OPENING STATEMENT OF GAIL R. WILENSKY,
JOHN M. OLIN SENIOR FELLOW,
CENTER FOR HEALTH AFFAIRS, PROJECT HOPE**

Ms. Wilensky. Thank you, Mr. Chairman, members of the Joint Economic Committee. I'm pleased to be here.

As you've indicated, I'm a former HCFA Administrator, now called Centers for Medicare and Medicaid Services. I also chaired the Medicare Payment Advisory Commission from 1997 to 2001.

I'm currently a Senior Fellow at Project HOPE and I also co-chair the President's Task Force to Improve Health Care Delivery for our Nation's veterans, which has proven to be an even greater challenge than reforming Medicare. I am, of course, here speaking as an individual, drawing on my experiences from HCFA.

I'd like to spend a few minutes talking about the financial liability of Medicare—I know you've heard a great deal about that—talk briefly about adding the effects of adding a drug benefit, and then to talk also about how well Medicare has restrained spending compared to the private sector and also to other large purchasing groups.

First, the financial challenges of Medicare are well documented and well known. The Medicare Social Security Trustees release a report about its solvency every year, as they did recently. It has indicated that things are not quite as good as they were last year with cash deficits in the Trust Fund, starting in 2013 rather than

2016, but even more importantly, continued rapid growth in Part B, the Supplementary Medical Insurance, which by the end of the decade is going to be almost 46 percent of total Medicare spending.

We frequently give a lot of consideration to what is going on in the Trust Fund. But because three-quarters of the Part B funding comes out of general revenue, it is at least as important to keep our minds on what is going on with Part B or SMI.

The effect of the economy on the Trust Fund is important. But basically, as we all know, the well-being of the Trust Fund is being driven by demographics.

The 78 million Baby Boomers, who are going to start retiring at the end of this decade will put significant financial pressure not only on Medicare, but also on Social Security, the Social Security Trust Fund, and on many of the services provided to seniors. At the same time, there is a bust generation following the Baby Boomers, so that we have the double whammy of having more people who will be retiring with fewer people who will be in the labor force supporting them.

Again, all of these facts are well known to you.

There is considerable discussion now about a Medicare prescription drug enacted anytime significantly after 1965, it would undoubtedly have included a drug benefit because that is a modern part of therapeutics.

The real question is what kind of a benefit we should have and how much other reform should go on at the same time. And I say that because as important as I think the drug benefit is for Medicare, it is not the only problem that Medicare faces.

When we look at the various drug benefit proposals we see, for example, that they range considerably in terms of how they might cost from approximately as little—and we didn't used to think of this as little numbers—as \$190 billion over 10 years to possibly as much as \$800 or \$900 billion over 10 years.

Obviously, with these kinds of differences, there are large differences in the kinds of benefits that are being proposed, who administers them and how that might affect seniors.

I also think it's important that we recognize that, if history is any guide, whatever we think the drug benefit will cost when we passed it, it will probably cost significantly more. This was certainly our experience with the end-stage renal disease program.

If we look at our experience with Medicare and Medicaid itself, if we look at what happened between the time that the Medicare catastrophic bill was passed and the time it was repealed, there was a significant increase in spending estimates associated with the bill even though the benefits were actually never implemented.

We ought to at least pause to realize that as large as these numbers seem now, before the benefits are enacted, the increase in spending probably will actually be significantly greater. But the absence of a drug benefit is not Medicare's only problem.

And that's why I have long advocated a drug benefit in the context of broader Medicare reform. And I continue to believe that is important. There are large cross subsidies in Medicare and a lot of inequities in spending.

Your State in particular is well-known because it is such a low spending State. Yet, the Medicare Part B premium is exactly the same for your beneficiaries as for your neighbors' beneficiaries.

Senator Bennett. We are penalized for the fact that we have a healthy population.

Ms. Wilensky. And because your physicians have a conservative practice style. Both. Yes, absolutely.

Senator Bennett. That's another subject I'll get into.

Ms. Wilensky. There are also administrative complexities. I know that the House has recently—the committees of jurisdiction—have recently voted out a reform bill. This is as serious for many providers as the payment level issues.

The point is that the Medicare drug benefit is not the only problem with Medicare. And I would strongly urge Members who are considering a drug benefit to not only do that which adds money, but to look at the picture more broadly speaking.

You are the Joint Economic Committee and I'm an economist although I don't often wear that hat anymore. And so I'd like to close by talking a little bit about what we know about moderating spending in Medicare as well as spending outside of Medicare.

As you well know, Medicare is an administered pricing system, which means that reimbursement are not set by the market. They are set by the government. And it is a reimbursement system that primarily attempts to control spending by putting all the pressure on providers.

The reason is that most seniors have insurance coverage that covers the 20 percent co-payment in Part B, which might otherwise influence their behavior.

If you look at the comparison of Medicare to health spending in other areas, your assessment depends mostly on what period you look at and what you are comparing Medicare to—in general—not surprisingly, because Medicare is a big middle-class entitlement program.

Medicare and other measures of health care spending don't look that different over the long haul. This statement is least true if you compare Medicare to private insurance directly. But that's probably the least relevant comparison.

The first reason it is the least relevant comparison is that over the last 30 years, the share of spending that private insurance covers in terms of hospital and physician spending, has increased dramatically.

So what is being bought with private insurance has changed at the same time spending has changed?

If you actually look at a unit of private insurance coverage, the cost per unit has not changed very much.

What's more important though for this discussion is a comparison with large public purchasing groups. Most discussions of reform are not suggesting Medicare be converted just to private insurance. Most reform discussions make use of large public purchasing groups like the Federal employees' health-care plan or like CALPERS.

When you look at those comparisons, Medicare has done more or less as well—slightly better than FEHB according to some numbers, not quite as well as FEHB if you look at the after-negotiated

numbers, and definitely not as well as CALPERS, at least in the last 10 years.

I don't want to claim that the large groups are great savers relative to Medicare, but I think if you look at the experience of Medicare compared to the large public purchasing groups, you can't make the claim on Medicare's side either that Medicare is much better.

To me, the conclusion is that if you want to look at administered pricing programs as a way of constraining spending, I think you can say Medicare has not done a bad job. But it has frequently done so, by huge shocks to the system.

The biggest shock came from the 1997 Balanced Budget Act, where Medicare spending declined from a 10 or 12 percent growth per year in the mid-1990s to a small absolute negative increase to—0.5—a little negative a couple of years later.

That's a pretty big shock for the system. You've heard lots of complaints from the provider community about what BBA was doing to them.

If you are willing to continue very tight controls like the sustainable growth rate (SGR) in physician payment that ties overall physician spending to the growth of the economy, if you have the political will to do that, if you don't think that causes a real unfairness since it hits the conservatively practicing physicians the hardest, I think administered pricing systems can restrain spending about as well as any other physician.

Personally, it makes a lot more sense to me to put pressure on beneficiaries as well as on providers rather than only on providers. Otherwise, it seems a little bit like depressing the gas pedal and slamming on the brake at the same time.

So for me, reforms that try to change the behavior of both seniors and providers make more sense than those that only focus on providers. A final note—the future beneficiaries are going to be quite different than the current beneficiaries, especially the women.

Most of the women will have considerable times in the labor force. They will have a lot more experience with insurance plans. They may have more income. And they will be better educated.

We'll have to protect the existing seniors, but we shouldn't make future decisions about Medicare based only on our existing senior population.

Thank you very much.

[The prepared statement of Gail R. Wilensky appears in Submissions for the Record on page 81.]

**OPENING STATEMENT OF JOHN P. MARTIN, DIRECTOR,
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS,
ORGANIZATION FOR ECONOMIC COOPERATION
AND DEVELOPMENT**

Director Martin. Chairman Bennett, ladies and gentlemen, it's a great pleasure for me in my capacity as OECD Director for Employment, Labour, and Social Affairs to testify before you today on some of the findings from ongoing OECD research into how the different member countries of the OECD are seeking to deal with the common problem of rising health-care costs.

I would hope that this ongoing research would provide some useful lessons for your deliberations as you wrestle with the task of how to insure Medicare's long-term financial viability. I have attempted to summarize some of the lessons in my written testimony, which was submitted beforehand. I won't repeat them now.

I would like, however, to highlight a few crucial points that need to be considered when reviewing the lessons from other countries and attempting to decide how they might be applicable or not, as the case may be, to the United States situation.

The first point I think it's important to emphasize is that the U.S. health-care system is unique in the OECD area. This uniqueness, I would submit, is reflected in the following ways:

The United States has no national health insurance program and does not provide universal coverage to its population.

A second unique feature is that it spends the most on health care, whether in terms of GDP or per capita, but its population health status is about average.

A third unique feature is it's a very responsive system as viewed from abroad, adapting very quickly to shifts in consumer preferences, much more so than the health-care systems in many OECD countries.

It fosters innovation in medical technology and seems to be able to disseminate this medical technology much more rapidly than is the case in other OECD countries.

A final feature of uniqueness is it's an extremely diverse system—highly decentralized and assigning a very large role to the private sector, which means that there are fewer policy levers at the Federal level to change health-care delivery directly than is the case in many OECD countries.

Thus, the U.S. system is really unique among OECD countries in its heavy reliance on competition across health-care insurers and providers in order to meet health-policy goals.

Now, I would submit that because of these unique features, it's obvious that there's no simple way to transfer lessons about what works and what doesn't work in other countries' health-care systems to the United States as a whole.

However, there may be lessons that are particularly relevant to Medicare, a program that has much in common, I would submit, with the publicly financed social-insurance-based health programs which are common in many OECD countries.

A second point to bear in mind is the stark fact that all OECD countries are facing a common challenge of rising health-care costs, just as is the United States. Health-care spending is absorbing a growing share of GDP in all countries despite one to two decades of cost-containment efforts in many of them that resulted in temporary successes in a few countries, especially in the early 1990s.

In addition, there is widespread agreement that these spending pressures on health care are likely to increase in the coming decades. Recent OECD projections of health-care spending in many member countries and those reported by the CBO in its written testimony for this hearing concord in their conclusions. Health spending is likely to represent a growing share of GDP over the coming decades in the United States and in virtually all other OECD countries.

Demands for health care will increase with improvements in medical technology and also with population aging. This immediately raises a question: Should we be worried by this trend?

The answer is not obvious. Spending more on health care as a society gets richer is not necessarily an inappropriate social choice. But we have to admit that it's extremely hard to judge what is the appropriate level of health spending in democratic societies.

There are clear risks of excess spending arising from the market failures which are associated with health care. And the government interventions in our societies that aim to remediate these market failures often result in other distortions elsewhere.

At the same time we're faced with much evidence across all OECD countries that it may be possible to obtain equivalent health outcomes for less spending and that there are obvious opportunities to improve health outcomes in many areas.

It's for this reason that there has been much emphasis recently in OECD countries on the need for health-sector reforms to promote efficiency—but efficiency not coming at the expense of effectiveness or quality care.

Now, while many reforms have been tried and some of them are described in my written testimony, I think it's fair to conclude that the scope for potential improvement is still very large.

But choices about further reform are hampered by the lack of comparable and up-to-date information about the impacts of the many reforms that have been enacted by OECD countries to date.

The OECD, the organization to which I belong, with the active support of many of its member governments, including the United States, has recently launched a major research program to try to fill in some of these gaps in knowledge. And we will be submitting a major report to OECD ministers in about a year's time seeking to draw some lessons from this work.

I hope this report, when it appears, will be helpful to the work of this Committee.

Thank you very much.

[The prepared statement of John P. Martin appears in Submissions for the Record on page 93.]

**OPENING STATEMENT OF MARILYN MOON, SENIOR FELLOW,
THE URBAN INSTITUTE**

Ms. Moon. Thank you, Mr. Chairman and Mr. Stark and other Members of the Committee. It's a privilege to be here today to speak to you about this important issue.

My understanding is the hearing is to look at the issue of the viability of Medicare. And my overall conclusion is that Medicare is indeed a viable program.

There are important challenges that face the Medicare program, but I wouldn't characterize them as a crisis. I would rather characterize them as important challenges that we're going to have to meet.

We are not going to do away with an aging society by any waving of the hands. And the notion that there will be more people over the age of 65 in the United States is a fact of life.

We are going to be living with that essentially forever. It's not even the pig in the python. It's the python in the python—that is,

once we go up to a higher share of older persons we will stay there over time.

So there are going to be important adjustments that need to be made in the interim. This is not a short-term challenge by any means.

I'll try to make five points in my testimony today. And I'm going to go over several of them very quickly and concentrate on just a couple.

First, as some of those testifying earlier have said, the challenges of health-care spending are essentially the same in Medicare as they are in the rest of the health-care system. It's technology and improvements in health care that have largely driven higher spending. And in many ways, people are getting value for their dollars through these new activities.

Medicare has been and should remain part of the mainstream. And that's a challenge that needs to be kept in mind as well.

Second, Medicare, while a challenge for the future, is not a crisis, I believe, for reasons of looking a little bit more broadly than some people do in terms of what the challenges are for the future on the economy.

Part A is in pretty good shape and has been for the last 4 years, in part because of, as Gail Wilensky said, the Balanced Budget Act, but also because of the growth in the economy. And economic growth is a very important part of that.

Moreover, Medicare Part A, for example, over the next 10 years will contribute \$500 million more in revenues than in spending, something that people often forget when they talk about the future problems of this program.

There is interest in combining Part A and B in terms of looking at the financial burdens. But I think that's a valid thing to look at. People have sometimes looked at it in the context of worker-to-retiree ratios, or the share of GDP that goes to the program. And both of those look to important aspects of the issue.

But it's also the size of the pie that will matter over time. To say that the share of GDP that's going to health care will undoubtedly grow as it will grow from health-care spending elsewhere in the economy, I think, is pretty much a given.

Americans have indicated that they like health care. They want to spend more on health care. And that's undoubtedly what's going to happen.

What does that mean in terms of Medicare? If you look at it in terms of Medicare as we often do and talk about burdens on workers for Medicare and look at the size of the pie, there is a chart in my testimony that essentially tries to make the point that the size of the pie is going to grow so much over time that actually there are going to be plenty of resources if we have the will to use them for that purpose.

As figure 2 indicates, the per-worker GDP, even after you control for inflation, will rise by 54 percent, or thereabouts, over the next 33 years. That growth is largely due to growth in expected productivity, based on relatively modest assumptions by the Medicare trustees.

If you then subtract the per-worker burden that Medicare will impose upon individuals from these resources and ask, will workers

continue to be better off after what we sometimes hear as an enormous burden for Medicare; the answer is that growth will decline. But it will decline from 54 percent to 51 percent.

I believe that indicates that the resources are there. The question is: Is the will there to deal with those resources?

Medicare will create an additional burden because we'll have a doubling of the population and we'll have nearly one in every four Americans covered by this program.

Third, I believe it's also important to use caution in assuming that beneficiaries can absorb fully the new burdens that will come along in the future. Even without changes in the program, a greater share of income of people 65 and over and who are disabled will be devoted to their health-care needs because health care will grow faster than the incomes of this population.

While they may be challenged to pay for part of the future costs, I think we have to be realistic in terms of raising that share too much.

Fourth, I believe that private plans are not the magic bullet answer. I would not argue that the work that Cristina Boccuti and I have done, where we show that Medicare has grown at a slower rate on a per capita basis than private insurance, indicates that Medicare is vastly better, but rather, if Medicare were turned over to the private sector, we would not suddenly find the answer to the problems that face Medicare in the future. That is, both private insurance and Medicare face the same problems of greater demands for health care over time.

Those who think that the private sector is the answer and will take us out of having to deal with higher costs are implicitly relying upon private plans to impose either very strict controls or raise premiums on beneficiaries over time.

That approach would be a second-hand way of solving the problem, but I think that people would be at your doorstep complaining just as surely as if we keep reliance on traditional Medicare programs in place.

Finally, because I believe there are important challenges facing Medicare, we should not shirk from thinking about changes in the basic Medicare program itself. Such changes should be a major consideration over time.

We should not, as Gail Wilensky has said, rely only on price controls. Indeed, the Medicare program over time has changed considerably, relying on payment policies that are both prospective and go beyond per visit or per unit of service basis.

We need to think more critically about areas to improve these payment systems, as well as ways, for example, to expand coordination of care activities through the basic Medicare program, because one way or the another, it's going to be there.

We haven't seen the kinds of innovation that we had hoped for from the private sector in the area of coordinated care. Everyone needs to work on this problem: the private sector, the public sector. And together, I believe that it can be there for people like me, a Baby Boomer who is part of the problem.

I hope we'll also be able to continue to benefit from the many things that Medicare has given seniors of today into the future.

Thank you.

[The prepared statement of Marilyn Moon appears in Submissions for the Record on page 104.]

Senator Bennett. Thank you very much. May I say I agree, Dr. Moon, absolutely that many of the problems that I have with Medicare also apply to what's happening in the private sector. This is not the place, but at some point, we might have this discussion.

I think the primary driver of problems in health care is the concept of a third-party payer, whether the third-party payer is a private insurance company that has been chosen by an employer or a Medicare system, where the provider is chosen by the government or endorsed by the government.

In each case, you remove from the customer any economic power to influence the outcome. Mr. Stark would insist that I'm too stupid as a customer to participate in that. We can have that debate between the two of us at some future time. But I think that is a major part of the escalating health-care costs in this country, both in the private sector and in the public sector. However, I find that—back to Mr. Stark's comment about we're the board of directors—I get far more complaints from the customers of the system that are under Medicare than I do from those that are in the private sector.

Indeed, when I turned 65, I was told by virtually everybody that knew anything about it: "Do not—do not—sign up for Medicare. Run for another term. Stay a Federal employee as long as you possibly can. Emulate Strom Thurmond if you can. But stay away from Medicare as long as you possibly can."

My ego is such that I respond to that kind of recommendation and I will run for another term, not only to avoid Medicare, but to continue to enjoy my job. And I think we're reaching the point where seniors need to do that and not look at automatic retirement at age 65.

The Balanced Budget Act has produced the economic results that you have given us. It has produced most of the complaints I get. And that the complaints do not exclusively come from providers.

There are a number of providers who simply say, "I will no longer see Medicare patients. That's the way I deal with the price controls, the cost controls that are put on providers. I simply drop out and cease to be a provider."

Interestingly enough, that was part of the debate in my first campaign for the Senate in 1992. There were at that time people saying, "I will not see Medicare patients." And Medicare patients were coming to me and saying: "If you get elected Senator, will you force the doctor to see them?"

And then, the Balanced Budget Amendment came in—or Act—came in in 1997. Instead of going to increased—well, instead of solving the problem, it exacerbated it. It made it much worse.

Now there are doctors who are saying to me, "Absolutely I will not see Medicare patients" or doctors who say to me, "I signed up to help people get better. I'm still going to do that," which means, "I will continue to see Medicare patients even though I am doing so at a loss with every single patient who comes into my office." And, "I have been forced out of my practice because my partners say having me as a partner in the overall group practice is hurting everybody. So I am personally, out of a sense of determination for

what I learned in medical school, subsidizing all of the Medicare patients that I see, that none of my former partners will see, by what I'm charging the other patients."

I don't know that that's just an anecdotal example that doesn't hold up. But I think it's one of the things we ought to address.

But as I say, not all of the complaints I get are from providers. I get the kinds of complaints I indicated when I talked about my own situation from people who say, "Do I absolutely have to go to Medicare at 65? Can't you fix it? You and the government who can fix everything—can't you fix it so that I can keep what I've got now? I'm willing to pay for it. My financial situation is such that I can handle it. I do not want to go into Medicare because the restrictions are so heavy that I want to stay exactly where I am."

So we've got ourselves in a situation where the customer satisfaction is going down and the costs are going up. And if the charts we saw earlier are correct, the costs are really going up.

That's why I've called this hearing. I think this is an area we need to address and think about. I'll be happy to get any response that any of you have. Or if you think about it, write to us. Keep those cards and letters coming. This is not a hearing that will end and we go away. This is a problem that the Congress faces and that I think has a major, major impact on the economy long term.

And if we are the Joint Economic Committee, we ought to provide the Congress with as much expertise on these problems as we possibly can as far away from political bickering as we can get.

Now, we can't avoid that because we're political animals. But let's do the best we can.

I appreciate this panel. Dr. Wilensky, let me respond to just a couple of issues you've raised.

I agree that the traditional Medicare program in some ways is going to be with us for a long time yet. That's where most of the seniors are. Whatever else we do, we need to make some changes so it operates in a more sensible way.

It penalizes conservatively-practicing physicians, because in its interest on restraining spending on physicians, it either lowers or raises the physician payment rates in accordance to physician spending in the whole country.

That hurts people who are conservatively practicing. Utah, among other places, is a conservatively-practicing State. That makes no sense. It doesn't treat chronic diseases very well.

So one of the things that we're going to have to do is recognize that traditional Medicare is going to be around for probably about as far as the eye can see. We need to do things to improve how reimbursement is paid to reward quality, to have measures for chronic disease.

Having said that, I very much agree that particularly with the people who are going to be coming into this area, although I have confidence in a lot of the seniors I know as well, that they ought to have other choices in their Medicare program.

That's why I personally have believed in the Federal employees' health-care plan as a good model. It allows a variety of health-care plans to be present, including some that would have a much smaller part of the third-party payer problem.

As an economist, I certainly don't disagree that a lot of the difficulties that we face in health care are related to the fact that somebody else is paying the bill. Health care does have some problems that it's going to always have, a significant portion of a third-party payer at least beyond some point.

We basically excluded any possibility of having plans that have more economically sensible kinds of cost-sharing mechanisms associated with it. That doesn't make any sense.

Neither does it make sense to force somebody who is continuing to work—which I hope more and more seniors will do—than not to be able to continue with their private health-care plan.

So I think we need to recognize the realities, at least as I see them, which is traditional Medicare is going to continue. Make that a more sensible program, but to move to a structure that allows for different kinds of plans and different kinds of cost-sharing as well.

We will end up spending more on health care because we have a huge change in the demographics. I don't think we sensibly can argue, especially because we are also a wealthy, and hopefully, increasingly wealthy society—the real question is how much more and how do we distribute that financing burden.

Those are not small issues. They have huge ramifications on the growth in the economy as well as on equity and distributional issues, so there are many questions. But it will have a very large impact on the economic growth on this country as to the kinds of responses we make to those challenges.

So I don't think it's particularly useful to say: Are we going to spend more on health care? The answer is: Of course. The answer is how much more and does that make sense.

Senator Bennett. Dr. Moon.

Dr. Moon. Thank you. A number of issues that you raised are important and interesting issues. When you look at all the data, Medicare beneficiaries report that they are happier with Medicare than do privately covered, insured individuals.

It is an interesting conundrum, because a lot of people's frustrations with Medicare is with the lack of what it covers in its benefit package. It is inadequate and has been for some time.

For example, about 82 percent of all people in private insurance have better benefit packages than Medicare beneficiaries do, which is also why beneficiaries rely on supplemental insurance, which causes coverage to be very complicated for this group. Hopefully, Medicare could be improved by expanding basic coverage and eliminating some of the need for the supplemental insurance.

The other issue that is important to stress is the lack of good information for a consumer on what's necessary care and the credibility of the people telling them that.

Sometimes, people in managed care, when told they are not getting access to a particular test, immediately assume that it's for financial reasons only. Sometimes they are correct, but other cases it may be that the test was unnecessary.

If we are going to talk about empowering consumers, which we certainly are doing a lot of right now, we have to give them the real tools to empower them. That is, we have to have credible sources of information.

Actually, the European countries have a lot to teach us about providing information. They do a lot of work on assessing appropriateness and spend time on that. That's one area where I think Medicare can contribute as well, because providing that kind of information represents a public good.

Finally, I would mention that I believe that another important thing to talk about in terms of Medicare's future is the issue of whether or not individuals will have choices.

I think it's fine to have private plans, but I don't think we should force people not to have traditional Medicare if that's what they want.

Personally speaking, my husband works for the University of Maryland, so we have 14 plans to choose from. But the realities are that we have four physicians that we rely on substantially, none of whom are in any of the managed care plans.

And the only one where we get any coverage at all is Care First of Maryland, in which I see my internist out of network. She charges me \$75, a very reasonable amount, for 20 minutes in downtown Washington. She charges that \$75 to me. I pay it. Care First says that's worth \$32.10 and pays 80 percent of that. Medicare pays her \$58 for the same visit.

Medicare is the only insurance program she takes, because my physician is being squeezed much harder by private insurers in this area. It varies around the country. But it's a problem that we don't have a good solution to.

I would also add that I think a lot of attention needs to be paid to finding ways to get physicians and consumers to work together in a concerted way to this as they are both in it together—and work together. And I think that means some major changes in policy.

Senator Bennett. Mr. Stark.

Representative Stark. Mr. Chairman, thank you. We've had votes called on the House floor, so I'm afraid Ms. Maloney and I—

Senator Bennett. I apologize.

Representative Stark. That's all right. The bells just went off. But I just wanted to say quickly before I dash out the door that I'm particularly glad to see Gail here. She's one of the few Republicans that I've worked with for more than 18 years on Medicare issues that I really truly believe does not want to destroy Medicare as an entitlement.

We often disagree, but I don't distrust her. Actually, you at least hold out the possibility that I do not want to.

[Laughter.]

Representative Stark. Mr. Chairman, as long as you raised the issue, I wanted to encourage the idea that you are at least five or ten times smarter than I am.

But I do believe that what Ms. Wilensky was getting at, and that Dr. Moon just pointed out, is that for most of us, medical technology and procedures are confusing.

And when, Gail, you talk about providers and beneficiaries being involved, I don't see how a woman—and I've had acquaintances who have dealt with breast cancer and the variety of protocols that are available for treating it—and, yes, you can go on the Internet.

But it does seem to me that when you are scared and sick and concerned, that making the kinds of rational decisions become even more difficult. And it isn't out there.

How do you decide? This is something—I'm one of the very few Medicare beneficiaries that goes through the problems of having to decide whether our family should be involved in the C-section or a vaginal delivery.

[Laughter.]

Representative Stark. But I'll tell you that this makes a great difference in the cost of medical care, not so much to Medicare, but most beneficiaries are somewhat more prudent than I am in that regard.

Nonetheless, women are faced all the time with the habits of what doctors do in a community. So one community does two or three times more C-sections than the other. The problems are the same.

I don't think it's fair unless, Gail, you are talking about cost-sharing on beneficiaries to reduce or increase utilization. And I get a little more cautious when I go down that road, because we started out years ago talking—you and I and Mr. Gradison—about outcomes research. And I think that's where Mr. Martin would agree with us.

And I think you would agree that we're not doing enough—and the Federal Government is the only one who can do outcome research, because everybody else is saying, "I ain't going to tell you." Blue Cross won't talk to anyone. They won't talk to Kaiser because they all think they've got some kind of special treatment situation.

So there are some areas where I think we could add to the body of knowledge and figure out how to pay physicians based on outcomes—not based on outcomes on a per case basis, but based on outcomes that procedures would warrant because of the historical value.

So Uwe Reinhardt mentioned yesterday that we spent 2 percent—and we brag on that—for HCFA. But you spent like 300-some percent on research on outcomes. HCFA could do that and we could do a whole lot.

If we want to get into competitive bidding, I have no quarrel with that. The places we tried it didn't like it. The providers, they hated it.

So it's easy to say let's have competitive bidding. But you find the hospitals or the doctors that are going to let us get away with that and I'll be right there with you.

So I appreciate your calling these hearings. And I want you to talk more to these witnesses. And I wish I could stay here and hear more of what Mr. Martin has to say.

But I thank you again for having these hearings. And I think we should do more on it.

Senator Bennett. That's all right, sir. We will do our best. You're in trouble now because you have only one man here who doesn't need to worry about the clock.

[Laughter.]

Representative Stark. Will you run for re-election even if I'm chair in the next Congress?

Senator Bennett. You are making an assumption there, Mr. Stark.

[Laughter.]

Senator Bennett. I don't know how much more productive time we can spend together, but let's just take advantage of your being here to talk about this question of the third-party payer. Let me go farther than that.

Clearly, a third-party payer is necessary in any situation where there is a clear financial emergency. I will give you a rough analogy, which I recognize, like every analogy, is flawed, but which I hope will make the point.

We talk about this as health insurance. And I think that is a distortion of the word "insurance" and the concept of the word "insurance" because it is not insurance. It is a payment system that we call insurance.

Here's the analogy. I have a homeowner's insurance policy. And it's a wonderful policy. If my home burns down, it will replace everything. It will replace the silverware in the drawers. It will replace the linens in the closet. It will replace the pictures hanging on the walls, as well as the Steinway piano and the valuable things.

As I examine the policy, however, no matter how carefully I look for it, I cannot find a clause in the policy that covers the cost of mowing the lawn or repainting the front door when the dog scratches it, or replacing the furnace filters when they get dirty.

But our attitude toward health insurance—and I in this case put the word "insurance" in quotes—is that somehow everything related to health must be reimbursed by the insurance company.

Obviously, we have to have a third-party payer if I'm going to have a quadruple bypass. I can't handle that.

But just as I handle the replacement of the furnace filter in my house and the big expense when my wife says to me, "There are too many scars on the wall and we've got to repaint the place," and that's a \$2,500-\$3,000 hit to repaint the place, but my insurance won't pay for that. It will only pay if I have a catastrophic event in the house.

Now, we've gotten away from that concept of insurance in health care. We are not insuring against a catastrophe. We are using the insurance company as the channel through which we funnel payments for everyday kinds of activities.

And when that gets too expensive, then we use the government and other countries. So the government in the analogy reimburses me for mowing the lawn.

And then they say, "Well, it's costing us too much, so we'll have a co-pay." So I have to keep the records of what I pay, the teenage boy next door, and then file a form so the government can reimburse for its share—the government, if it is Medicare, the private insurer if I'm not on Medicare, for its share of the cost of mowing the lawn.

And that to me makes absolutely no sense. I have talked to insurance companies and said, "What would happen if you had a \$3,000 deductible, a true deductible?"—not the kind of deductible that we've built in to health insurance where you keep all your little chips, add them up, and then you go in and say, "Ahah, I've the

magic number and you pay everything over this." A deductible like my car insurance deductible that says I've got \$1,000 deductible and if I get into a \$900 accident, I have to pay the full \$900. And if a week later, my wife gets in a \$900 accident, she has to pay the full \$900.

But somebody totals the car, the whole car is paid for, minus that \$1,000. Insurance companies I talked to said if we had a \$3,000 deductible, we could cut the cost of insurance almost to the level of your homeowner's policy.

In the emergency room, they said 90 percent of the people that walk into this hospital in the emergency room cost less than \$3,000. Indeed, 80 percent cost less than \$1,500.

If for people who came in for an emergency that costs less than \$1,500 and simply hand us a VISA card and check them off and sent them forward, we could fire half our staff involved in filling out all those forms. And then the checking, and then the looking for fraud, and the backwards and forwards, and was this really done, and so on and so forth. The customer knows what was done. The customer gives you his credit card. The customer leaves.

And if there is a true medical emergency, if you are talking about we are going to have a C-section or we are going to—all of these other problems—OK, now you sit down and say, "Let's get the medical advice we need."

But I break my finger, which I did. It's practically a commodity to go in, set it, and look at it. Now, to be true, after I broke my finger, I then went to a friend of mine who is a hand specialist in Utah. And he looked at the way it was done at Bethesda Naval Hospital and says, "Let's do it again." And he changed it a little.

But there was nothing wrong with the way it was done at Bethesda. I just happened to have a friend who specialized in sports medicine and has repaired the fingers of people like Steve Young and other people who get their fingers broken.

I understand that the \$1,500—if we made a \$1,500 deductible—is a challenge. But I'm currently spending—my employer and I—in excess of \$500 a month to pay for the present system. My employer pays over \$350 and I pay over \$150. It's \$5-\$600 every month.

If I could take a portion of that and buy a catastrophic policy with a \$1,500 deductible and put the rest of it in a medical savings account that did not get taxed, I would very quickly have \$1,500 available to cover any deductible that would come along.

And I would have an incentive to take care of myself so that I wouldn't have to spend that \$1,500, because it would be available to me to spend on something else if I didn't get sick.

Now, react to that. Tell me what's wrong with it.

Ms. Wilensky. We're in a country where people have gotten so used to having insurance that is prepayment as opposed to insurance that's insurance. One of the difficulties you have trying to get people to think differently about health care.

Senator Bennett. I understand that.

Ms. Wilensky. I personally think that we should use insurance as insurance, that is, paying for a high cost, low probability event. People who want to prepay because they don't want to deal with

issues of price need to put themselves in a system where somebody else is dealing with the cost of care.

That was initially the idea behind HMOs and managed care. Of course, people then decided that they didn't like it if somebody was restricting their use once they had gotten into managed care.

We are in a very difficult position, because with employer-sponsored insurance, many employees don't think about the employers' contribution as their money, although it is. So when they think about what it's costing, it's only the amount they see directly.

So the question is: How can we proceed from here?

It strikes me that since we are where we are, the best we can do is to make sure that both employers and seniors who want a system where insurance is being used as insurance with less involvement by others have that opportunity. Whenever you have third party payment covering expenses, the third party is rightly going to say, "We want to have some say in where you go, how you spend and what you spend. And we want records and we want to make sure you're not ripping us off."

In order to at least try this as an option, as well as to make sure that there are other options available, both the under-65 employer level and for seniors, we have to find a way to treat major or catastrophic expenses. I don't want to diminish the importance of having individuals more involved in their own health-care decisions, because even small percentage changes in a \$1.3 trillion sector can make a big difference.

But health care is notorious for having concentrations of spending—relatively small numbers of people, spending large shares of the health care money.

What this does is push this issue that Mr. Stark raised: Are we getting better information now about what works when?

Rewarding individual physicians is hard; it's much easier if a physician is part of a plan—rewarding physicians who practice better, who do the things that count and don't do the things that don't count, reward them for being conservatively practicing physicians.

Interesting studies have been coming out in 2003, both ranking States as best they can about the quality improvement using Medicare data, and another one looking at what high-spending areas actually buy. And it's mostly discretionary spending that neither improves quality nor quantity of life.

The question is what to do in Medicare, since we let local physicians make decisions about how they practice Medicare controls, prices, and physician reimbursement. But Medicare doesn't interfere in how Medicare is practiced as long as it fits with broadly defined concepts of being medically apportioned.

We know there are huge variations in spending across the country and it's not clear what the country is getting for this. So I'd agree with you, but I think we need to recognize that in health care we also have to think about what we've going to do for those relatively small numbers of people who spend huge amounts of money, much of which may not be particularly medically beneficial and to do so in ways that will make us all comfortable that these are good medical decisions.

They're not financial credentialing, or economic credentialing as doctors like to call it, but that what is being done clinically makes sense. There's a huge range out there.

I'm not as confident as Marilyn that we can look to you to figure this out. I don't think we know very much yet about what works when. We've been reasonably aggressive in the public health service in investing in that. But nothing compared to what we should be doing.

Senator Bennett. Dr. Moon.

Ms. Moon. I see three practical issues in talking about this for Medicare. In addition to the issue Gail raised about getting from here to there, which is hard to do, the first is the issue of risk.

If you have two different plans in which people can choose one with a high deductible while the other is more comprehensive, you're going to tend to have people flow into the more comprehensive program who are sicker. There's a real problem of how to do that fairly in terms of payments to plans.

Second is an issue that needs to be taken into account anywhere, but in particular in Medicare. The issue is income. What is a high deductible for me is very different than what's a high deductible for an average 80 year old lady on the Medicare program.

Senator Bennett. I'm not describing this as Medicare.

Ms. Moon. The third issue relates to the chronically ill. That is, some people will ring the bell in spending by going in and having heart bypass surgery who have never had any symptoms, et cetera. Other people have to see the doctor once or twice, every couple of weeks, and do a lot of testing that can be very expensive to maintain chronic conditions.

In these examples, the first person would reach the deductible and get help. But after you have 30 or 40 physician visits a year and 60 very sophisticated tests you will also have spent a great deal, but never have met the deductible.

I understand your goal. And I think it's an admirable one. Speaking as a consumer, not to have to keep track of all those bills would be nice as well. But it also means that when there's a high deductible the way it works now—and I understand the distinction you were making—I have to keep track of everything. And then my insurance plan has to go back and make sure that I've spent \$1,000 before I hit that deductible.

So, insurance companies tend not to like it—the way it's normally characterized. The way you're talking about it, I understand, would be different.

But because of the chronically ill and the need to really look at cumulative expenditures, I'm not sure you could do it your way.

Senator Bennett. Yes, sir.

Mr. Martin. I think this is a very fascinating question that you've posed to us, Senator. There are a lot of issues. Let me just try to make a few points.

First of all, I think it's correct. It's very clear that if you wanted to move to a system like the one you were describing, you need to worry a lot about the appropriate regulation of the insurance markets that would accompany it, because you have a classic problem of cream-skimming. How are you going to develop appropriate risk-adjustment factors that will insure that you achieve adequate cov-

erage? This is a problem that you see in many OECD countries because many of them are committed to achieving and maintaining universal coverage.

Let me just give you an example from one country. Switzerland has mandatory private insurance combined with universal coverage of the population. It moved to mandatory private insurance in 1994, but at the same time it combines this with very extensive regulation of the many private health insurance schemes which operate in Switzerland.

It does so because it wants to maintain the goal of universal coverage. Therefore, it imposes various rules regarding community risk-pooling and risk-adjustment in order to insure that you can maintain that coverage.

Now, the interesting thing that comes out of this is that there is some competition between the private insurance schemes in Switzerland. They do charge different premiums across the country.

And the interesting thing is that for the moment, there isn't much response by the average Swiss consumer to these different premiums and these different incentives. There's actually relatively little flows between schemes.

You can interpret this fact in a number of different ways. One I think is very much to the point that Gail and Marilyn have been making and one that I would also emphasize.

Consumers, that is, people like us, are not that well-informed about the advantages and disadvantages of different private insurance schemes. We have great attachment to the things that we know, especially where health care is concerned.

We like our doctor. We like our local hospital. We are very fond of our long-standing private health insurance scheme.

In order to change that you really do need to have as a Nation an effective system of information-gathering and dissemination on effective practices, that is, disseminated well to both providers and to the consumers.

And that is a very difficult task. I would not agree with Marilyn that many European countries do it better than the United States actually.

I think Gail is right. All OECD countries, in my view, do this very badly. They are not good at collecting and disseminating good information on best practices and the utilization of best practices and then creating incentives for individuals or companies to use that information appropriately in the market for purchasing health-care services.

That's a real challenge. It might be—and we've heard some interesting arguments—that maybe one can design new savings accounts, medical savings accounts, that would create sufficient incentives for consumers and providers. But I think that requires a lot more information and a lot more experimentation to be absolutely certain.

The potential gains are quite large. I agree with you on that, Mr. Chairman. And I think that that kind of experimentation is very worthwhile.

And I submit in the context of a health care system like the United States, one which is so diverse and which is so open to

these kind of innovations, it would seem to me to be very worthy of experimentation.

I know that other countries would be extremely interested in seeing whether it's possible to design new insurance and savings accounts here that really will encourage much more effective value-based health insurance actions on the part of providers and clients. That's a real big challenge for us.

Ms. Wilensky. Let me just speak a moment, if I may, to the risks election issue. It is certainly, in theory—or at least potentially, out there anytime you have a significant amount of choice among health-care plans.

And the greater the difference in either coverage or benefits, the more you ought to think about it.

It is a little encouraging that a recent study that Kent Dorba and others reported on, the FEHB program, showed very little actual risk segmentation going on in the FEHB program, although the FEHB program does not do any risk adjustment at all, which strikes me as asking for trouble.

There are a variety of reasons he gives as to why he thinks that's happened. I don't argue that as a rationale for not doing risk adjustment, for example, Medicare—I think we need to do risk adjustment and we're about to start using some risk adjustment.

It's also possible to use a partial capitation system, where most, but not all of the payment to the plan is fixed ahead of time, but a portion of the payment reflects actual use.

That not only gives you a little cushion in case you don't get the risk adjustment exactly right. But even if you did get the risk adjustment right, you still have this problem—that if you have zero marginal revenue for a big user, the plan itself has some incentive to skip on services provided.

So if at least part of the payment is directly related to the use—not too much, but part of the payment—there are some positive gains. I only say that to say these are problems that I think can be handled. And I think they can't be handled perfectly.

But we don't need to handle them perfectly, just reasonably well.

I also hope, with Director Martin, that the United States tries a little more seriously some of these options, because we are one of the few places you can imagine demonstrations of this sort going on.

It's very hard to imagine in these very centralized European countries that they would even be willing to contemplate such changes.

Ms. Moon. I would just like to add that either I overstated or Director Martin didn't understand what I was trying to say.

I don't believe that the European countries have solved all the problems of providing information. But I think a number of them have made a commitment to investing and gathering that information and making the first steps.

Great Britain, Australia, Canada are all working very hard I know. And I assume some of the other countries are also trying to do head-to-head comparisons of drugs and techniques that are going to be useful in the future. And we're not doing very much about that.

Senator Bennett. Thank you very much. This is outside the scope of the hearing, because most of this conversation has to do with pre-Medicare kinds of insurance and private coverage. But I couldn't resist, having these three experts in front of me, to explore that.

Let me thank you for your willingness to indulge me in this conversation and for your participation in the hearing today.

The hearing is adjourned.

[Whereupon, at 12:45 p.m., the hearing was adjourned.]

Submissions for the Record

PREPARED STATEMENT OF SENATOR ROBERT F. BENNETT, CHAIRMAN,
JOINT ECONOMIC COMMITTEE

Good morning and welcome to today's hearing on the challenges facing Medicare. Medicare is the best Blue Cross/Blue Shield fee-for-service indemnity plan of the 1960s—frozen in time. Before we get carried away with rhetoric about what we have to protect and not protect about Medicare, let's understand that simple truth. We don't practice medicine the way we did in the 1960s; we shouldn't deliver and finance medicine the same way either.

Congress must face the fact that Medicare is 40 years old, whereas the practice of medicine is changing so constantly that we could say it is only 40 months old. Applying another Band-Aid to Medicare would be malpractice when radical surgery is what's needed.

Exhibit 1 in the case for radical reform is Medicare's growing financial crisis. Promised benefits now exceed Medicare's financial resources by more than \$13 trillion. In other words, Medicare's unfunded liabilities are more than three-and-half times as large as our Nation's public debt. This imbalance will only worsen if Congress adds a prescription drug benefit to Medicare.

We have a big problem—one that gets worse every day. To bring Medicare into long-term fiscal balance today would require either an 83 percent increase in the Medicare payroll tax or a 42 percent reduction in Medicare spending. If we wait, these changes would have to be even larger. Enormous burdens on Medicare beneficiaries and on taxpayers thus appear almost inevitable.

We need better solutions. We need creative ideas about how to deliver quality care to a growing population while keeping costs under control. We need, in short, to start over with a clean sheet of paper. We need to ask ourselves—"Given everything we know today, what's the best way to structure Medicare and, indeed, our entire health care system?"

Any successful reform must begin with respect for the power of the market. Consumer choice, consumer responsibility, and market competition have long driven the success of the U.S. economy. The same forces should be harnessed to deliver health care.

Properly structured, market-oriented reforms can deliver quality health care efficiently and fairly. Market forces will increase beneficiary choice, slow the growth of beneficiary and taxpayer spending, and provide strong incentives for health plans, both public and private, to provide the highest quality health care.

Congress should take care to safeguard vulnerable beneficiaries from any unintended consequences of market forces. However, it would be foolhardy to walk away from all the benefits of market forces for fear of these unintended consequences.

We have a problem and it's not going to go away. Indeed, it seems likely to get worse, given the strong desire to add a prescription drug benefit. I share that desire—prescription drugs are essential to the health of our retirees. But as we design that new benefit, we should keep in mind that—as noted in a new Committee report released this morning—more than three-quarters of Medicare beneficiaries already have some sort of drug coverage. Any move to add a drug benefit must carefully balance the needs of the beneficiaries with their current sources of coverage and the financial burden on taxpayers.

We certainly do need a prescription drug benefit—prescription drugs do things now that were unimaginable in the 1960s. But we shouldn't paste that benefit onto a broken system. We shouldn't create a new set of forms and eligibilities that torment patients, frustrate doctors, and reward those skilled in the black art of Medicare payment formulas. Let us as a Congress face the fact that we need to start

from a clean sheet of paper, all over again, with all of the money we are putting into it, and say “Let’s create a whole new system.”

PREPARED STATEMENT OF REPRESENTATIVE PETE STARK,
RANKING MINORITY MEMBER

Thank you Chairman Bennett for holding this hearing. I would like to welcome our witnesses and thank them for testifying here today about Medicare’s finances.

The title of this hearing, “Medicare’s Viability and Financial Situation,” is intended by the Republicans to be a leading suggestion that Medicare isn’t viable and is in a horrible financial situation. Thankfully, the facts point out a much different picture. This is more about the ideology of Republicans than the reality of Medicare’s current standing.

Medicare’s solvency is at the second highest point in the program’s history. Right now, Medicare is solvent until 2026. In 1997, before we passed the Balanced Budget Act, the program was to become insolvent in 2001—just 4 years into the future! Yet, Medicare is still here. I just say this to point out that the Republican attack on Medicare’s viability is a scare tactic to enable them to achieve their real goal: dismantling Medicare as entitlement program that provides guaranteed benefits at guaranteed prices.

Medicare is better than private plans at controlling costs. A recent analysis by Urban Institute Economist and former Medicare Trustee Marilyn Moon, who will be a witness at our hearing today, highlights that Medicare has consistently done a better job at controlling health care cost growth than the private sector has. I’ll leave it for her to discuss that analysis in greater detail.

The major problem facing Medicare’s future is whether we in Congress are willing to make the changes necessary to assure its viability for the future. The most important change we can make in that regard is to add a Medicare drug benefit. Of course adding a drug benefit will require increased spending. The President and Republicans don’t seem to question increased spending when it comes to tax cuts for the wealthy. But when it comes to a Medicare drug benefit, the response is always “it is too costly to do a real drug benefit.” I don’t think that is the case.

Republicans also argue that a Medicare drug benefit can’t be added to the program unless substantial “reform” is attached. My question is what do they mean by reform? Do they mean something like the President’s outline of a plan that would force seniors to enroll in private managed care plans in order to receive decent prescription drug coverage, while those in traditional Medicare would receive minimal drug coverage. The Faustian bargain presented to seniors is to receive the drugs they need in exchange for giving up comprehensive health coverage with their choice of doctors. That’s not a fair choice at all—and not one any of us in Congress are forced to make. Seniors shouldn’t be forced to either.

Government Accounting Office estimates show that foregoing additional tax cuts beyond current law would provide an additional 25-year window for Medicare solvency while we consider how to slow health care costs. At a minimum, this should be done.

Dr. Holtz-Eakin has referred to the Medicare Trust Funds as merely “bookkeeping devices” used by the Treasury. I would submit to you that a “trust” fund is much more than that. A Trust Fund is a promise—Medicare is a promise to 40 million elderly and disabled Americans that they will receive quality health care. Medicare will be there for people who need it, so long as politicians here in Washington keep that promise.

I look forward to the testimony of our witnesses.

PREPARED STATEMENT OF SENATOR EDWARD M. KENNEDY

I commend The Chairman for calling today’s hearing on the 2003 Medicare Trustees Report, the long-term viability of Medicare, proposals for a prescription drug benefit, and other reforms. But the title of the hearing is misleading—“Medicare’s Financial Crisis.” It’s easy to use that phrase to try to privatize Medicare and force seniors into HMOs. But the reality is that Medicare is far from failing.

In fact, in recent years, its solvency has improved dramatically. The 2003 Medicare Trustees Report says that the Trust Fund will be solvent through 2026, almost a quarter century from now. That’s a slight drop from last year’s projection, but it is still much better than a few years ago, when the Trust Fund was expected to become insolvent in 4 years. In fact, the 23 years of solvency in this year’s report are among the longest in the Trust Fund’s history.

All of us want to improve Medicare, and there are many areas where we should be working together. Most important, Medicare should have a prescription drug benefit. We should also be working to improve the quality of care under Medicare and for others too. Often, there are unacceptably wide gaps between the best practices and the care that patients actually receive. Improving care for patients with chronic illnesses such as diabetes and congestive heart failure will mean large improvements in health care and large savings for Medicare too.

We need to improve the use of information technology in Medicare and the health system as a whole to reduce costs and improve quality. WE need adequate payments to hospitals, physicians, and other providers, so that they can provide high quality care under Medicare and for all other Americans.

Many of these changes will produce savings in the long-term, but require significant investment in the short-term. Health care for seniors is obviously more important than large new tax breaks for the wealthy. These important health improvements should be a top priority. But that's far from saying there's a Medicare crisis, and no justification for the extreme changes that would reduce benefits or force senior citizens into HMOs.

I am particularly pleased that Marilyn Moon is here today. Dr. Moon wrote an important recent article on Medicare called "Solvency or Affordability? Ways to Measure Medicare's Financial Health." We all know that as the Baby Boom generation retires, the ratio of active workers to retirees will fall. Today, there are 3.9 workers for each retiree, but by 2035, the number is expected to fall to 2.2. Opponents of Medicare often use this fact to support their claim that major changes are needed in Medicare now.

Dr. Moon points out that the declining ration of active to retired workers is only half the story. The other half—the more important half—is the impact that supporting Medicare will have on active workers' living standards. Dr. Moon's article finds that even using the conservative assumptions in the Medicare trustees' report, workers' real incomes in 2035 will be 57 percent higher than they are today. After the cost of supporting Medicare is taken into account, their incomes will still be 54 percent higher than they are today. Far from being unsustainable, Medicare will actually be easier to support for tomorrow's workers than today's workers. So there are problems like prescription drugs that have to be solved. But let's not cry "wolf" about a crisis in Medicare—it's not even a mini-crisis. It's not a crisis at all, and it's certainly not a justification to privatize Medicare and push senior citizens into HMOs.

I thank all of the witnesses for appearing today and look forward to hearing their testimony.

United States General Accounting Office

GAO

Testimony
Before the Joint Economic Committee

For Release on Delivery
Expected at 10:00 a.m.
Thursday, April 10, 2003

MEDICARE

Financial Challenges and
Considerations for Reform

Statement of David M. Walker
Comptroller General of the United States



GAO-03-577T

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you examine Medicare's financial health and consider the budgetary and economic challenges presented by an aging society. I have been particularly attentive to the sustainability challenges faced by the nation's two largest entitlement programs—Medicare and Social Security—for more than a decade since I served as a public trustee for these programs in the early 1990s. The recent publication of the 2003 Trustees' annual report reminds us, once again, that the status quo is not an option for Medicare. If the program stays on its present course, in 10 years Hospital Insurance (HI) Trust Fund outlays will begin to exceed tax receipts, and by 2026 the HI trust fund will be exhausted. It is important to note that trust fund insolvency does not mean the program will cease to exist; program tax revenues will continue to cover a portion of projected expenditures.¹ However, Medicare is only part of the broader health care financing problem that confronts both public programs and private payers. The unrelenting growth in health care spending is producing a health care sector that continues to claim an increasing share of our gross domestic product (GDP).

Despite the grim outlook for Medicare's financial future, fiscal discipline imposed on Medicare through the Balanced Budget Act of 1997 (BBA) continues to be challenged, and interest in modernizing the program's benefit package to include prescription drug coverage and catastrophic protection continues to grow. Such unabated pressures highlight the urgency for meaningful reform. As we deliberate on the situation, we must be mindful of several key points:

- The traditional measure of HI Trust Fund solvency is a misleading gauge of Medicare's financial health. Long before the HI Trust Fund is projected to be insolvent, pressures on the rest of the federal budget will grow as HI's projected cash inflows turn negative and grow as the years pass. Moreover, a focus on the financial status of HI ignores the increasing burden Supplemental Medical Insurance (SMI)—Medicare part B—will place on taxpayers and beneficiaries.

¹Under the Trustees 2003 intermediate assumptions, revenues from the HI payroll tax and taxation of certain Social Security benefits are initially projected to cover about three-fourths of projected expenditures once the trust fund is exhausted. This ratio, however, is projected to decline rapidly.

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- GAO's most recent long-term budget simulations continue to show that demographic trends and rising health care spending will drive escalating federal deficits and debt, absent meaningful entitlement reforms or other significant tax or spending actions. To obtain budget balance, massive spending cuts, tax increases, or some combination of the two would be necessary. Neither slowing the growth of discretionary spending nor allowing the tax reductions to sunset will eliminate the imbalance. In addition, while additional economic growth will help ease our burden, the potential fiscal gap is too great to grow our way out of the problem.
 - Since the cost of a drug benefit would boost spending projections even further, adding drug coverage when Medicare's financial future is already bleak will require difficult policy choices that will mean trade-offs for both beneficiaries and providers. Just as physicians take the Hippocratic oath to "do no harm," policymakers should avoid adopting reforms that will worsen Medicare's long-term financial health.
 - Our experience with Medicare—both the traditional program and its private health plan alternative—provides valuable lessons that can guide consideration of reforms. For example, we know that proposals to enroll beneficiaries in private health plans must be designed to encourage beneficiaries to join efficient plans and ensure that Medicare shares in any efficiency gains. We also recognize that improvements to traditional Medicare are essential, as this program will likely remain significant for some time to come.

Ultimately, we will need to look at broader health care reforms, as spending growth problems are not exclusive to Medicare. For both public and private payers, containing growth in health expenditures will be an abiding 21st century challenge. In today's health care sector, there are few incentives for providers and consumers to be prudent in their ordering and use of health care services, too little transparency with regard to the value and costs of care, and inadequate accountability to ensure that health care plans and providers meet standards for appropriate use and quality.

These problems cannot be solved overnight. It will require committed, long-term resolve and sustained attention to help policymakers and the public understand the need to move beyond the status quo. The magnitude of the challenge suggests that reforms will need to be phased in over time to minimize any temporary disruptions that may result. However, incremental reforms should build upon each other and continue to bring us closer to our desired goals. This argues for having a systematic process for setting common goals and assessing the potential for any proposed reforms to meet these goals. At GAO, we are developing a framework—

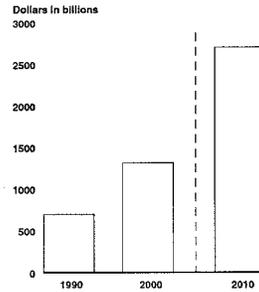
that is, a comprehensive set of criteria—for consideration by the Congress, to help policymakers evaluate proposed health care reforms.

Now I would like to discuss overall trends in health care spending, the financial challenges Medicare faces, and considerations for health care reform efforts.

Trends in Health Care Spending Systemwide Pose Significant Challenges for 21st Century

To best understand Medicare's fiscal plight, we should also understand the broader health care context in which it operates. Total health care spending from all sources—public and private—continues to increase at a breathtaking pace. From 1990 through 2000, spending nearly doubled from about \$696 billion to about \$1.3 trillion (see fig. 1). From 2000 through 2010, the rate of spending growth is expected to accelerate somewhat, resulting in an estimated \$2.7 trillion in total annual health care spending by the end of the period. Increases in medical prices account for a little more than half of the 20-year spending increase, while increases in the use of services—owing to population growth and rise in the number of services used per person—and more expensive services account for the rest.

Figure 1: Total National Health Care Spending, 1990–2010

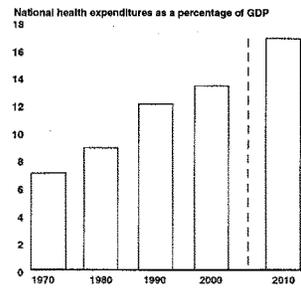


Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group.

Note: The figure for 2010 is projected. All dollars are nominal.

The rapid growth in health care spending means that an increasing share of the nation's output, as measured by GDP, will be devoted to the production of health care services and goods. In 1970, spending on health care represented about 7 percent of GDP (see fig. 2). By 2010, health care spending's share of GDP is expected to rise to about 17 percent.

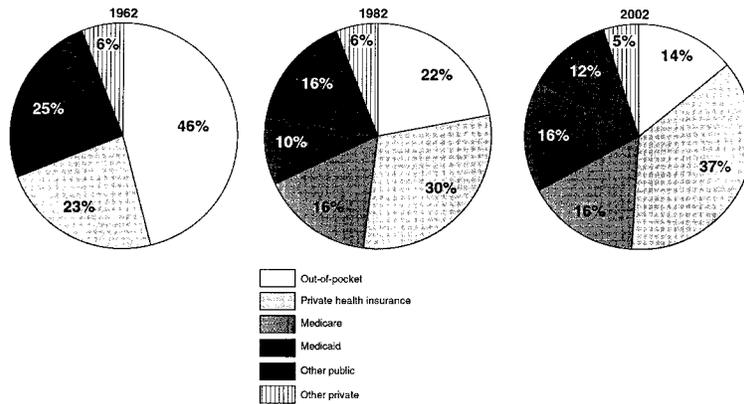
Figure 2: Total National Health Care Spending as a Percentage of GDP, 1970–2010



Sources: CMS, Office of the Actuary, National Health Statistics Group and U.S. Department of Commerce, Bureau of Economic Analysis.
 Note: The figure for 2010 is projected.

At the same time that health care spending has increased, consumers have become more insulated from these costs. In 1962, nearly half—46 percent—of health care spending was financed by individuals out of their own pockets (see fig. 3). The remaining 54 percent was financed by a combination of private health insurance and public programs. By 2002, the amount of health care spending financed by individuals out of their own pockets was estimated to have dropped to 14 percent.

Figure 3: Sources of Health Care Financing, 1962-2002



Source: CMS, Office of the Actuary, National Health Statistics Group.

Note: The figure for 2002 is estimated.

Tax considerations encourage employers to offer health insurance to their employees, as the value of the premium is excluded from the calculation of employees' taxable earnings. Moreover, the value of the insurance coverage does not figure into the calculation of payroll taxes. These tax exclusions represent a significant source of foregone federal revenue, currently amounting to about 1 percent of GDP.

Outlook Worsening for Medicare's Long-Term Sustainability

Today the Medicare program faces a long-range and fundamental financing problem driven by known demographic trends and projected escalation of health care spending beyond general inflation. The lack of an immediate crisis in Medicare financing affects the nature of the challenge, but it does not eliminate the need for change. Within the next 10 years, the first baby boomers will begin to retire, putting increasing pressure on the federal budget. From the perspectives of the program, the federal budget, and the economy, Medicare in its present form is not sustainable. Acting sooner

rather than later would allow changes to be phased in so that the individuals who are most likely to be affected, namely younger and future workers, will have time to adjust their retirement planning while helping to avoid related "expectation gaps." Since there is considerable confusion about Medicare's current financing arrangements, I would like to begin by describing the nature, timing, and extent of the financing problem.

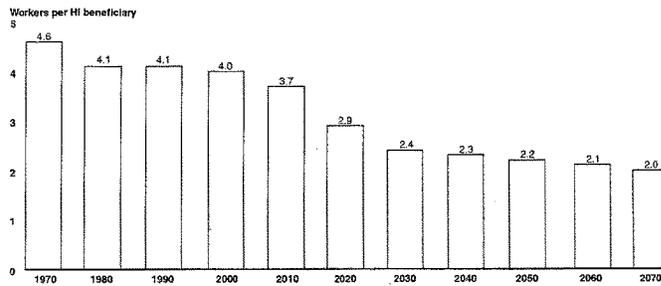
**Demographic Trends And
Expected Rise in Health
Care Costs Drive
Medicare's Long-Term
Financing Problem**

As you know, Medicare consists of two parts—HI and SMI. HI, which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services, is financed by a payroll tax. Like Social Security, HI has always been largely a pay-as-you-go system. SMI, which pays for physician and outpatient hospital services, diagnostic tests, and certain other medical services, is financed by a combination of general revenues and beneficiary premiums. Beneficiary premiums pay for about one-fourth of SMI benefits, with the remainder financed by general revenues. These complex financing arrangements mean that current workers' taxes primarily pay for current retirees' benefits except for those financed by SMI premiums.²

As a result, the relative numbers of workers and beneficiaries have a major impact on Medicare's financing. The ratio, however, is changing. In the future, relatively fewer workers will be available to shoulder Medicare's financial burden. In 2002 there were 4.9 working-age persons (18 to 64 years) per elderly person, but by 2030, this ratio is projected to decline to 2.8. For the HI portion of Medicare, in 2002 there were nearly 4 covered workers per HI beneficiary. Under the Trustees' intermediate 2003 estimates, the Medicare Trustees project that by 2030 there will be only 2.4 covered workers per HI beneficiary. (See fig. 4.)

²Another small source of funding derives from the tax treatment of Social Security benefits. Under certain circumstances, up to 85 percent of an individual's or couple's Social Security benefits are subject to income taxes. Under present law, the Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds are credited with the income taxes attributable to the taxation of the first 50 percent of OASDI benefit payments. The remainder of the income taxes attributable to the taxation of up to 85 percent of OASDI benefit payments is credited to the HI Trust Fund. Any other income taxes paid by retirees would also help finance the general revenue contribution to SMI.

Figure 4: Ratio of HI-Covered Workers to Beneficiaries



Source: CMS, Office of the Actuary.

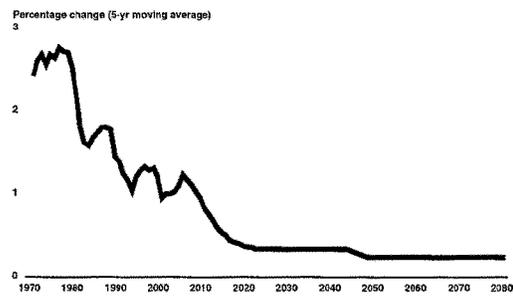
Note: Projections based on the intermediate assumptions of *The 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

The demographic challenge facing the system has several causes. People are retiring early and living longer. As the baby boom generation ages, the share of the population age 65 and over will escalate rapidly. A falling fertility rate is the other principal factor underlying the growth in the elderly's share of the population. In the 1960s, the fertility rate was an average of 3 children per woman. Today it is a little over 2, and by 2030 it is expected to fall to 1.95—a rate that is below replacement. The combination of the aging of the baby boom generation, increased longevity, and a lower fertility rate will drive the elderly as a share of total population from today's 12 percent to almost 20 percent in 2030.

Taken together, these trends threaten both the financial solvency and sustainability of this important program. Labor force growth will continue to decline and by 2025 is expected to be less than a third of what it is today. (See fig. 5.) Relatively fewer workers will be available to produce the goods and services that all will consume. Without a major increase in productivity, low labor force growth will lead to slower growth in the economy and slower growth of federal revenues. This in turn will only accentuate the overall pressure on the federal budget. This slowing labor force growth is not always recognized as part of the Medicare debate, but

it is expected to affect the ability of the federal budget and the economy to sustain Medicare's projected spending in the coming years.

Figure 5: Labor Force Growth



Note: GAO analysis based on the intermediate assumptions of *The 2003 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds*. Percentage change is calculated as a centered 5-year moving average.

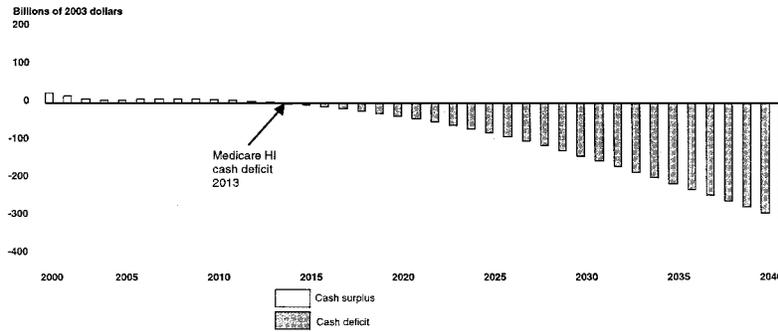
The demographic trends I have described will affect both Medicare and Social Security, but Medicare presents a much greater, more complex, and more urgent challenge. Unlike Social Security, Medicare spending growth rates reflect not only a burgeoning beneficiary population, but also the escalation of health care costs at rates well exceeding general rates of inflation. The growth of medical technology has contributed to increases in the number and quality of health care services. Moreover, the actual costs of health care consumption are not transparent. Third-party payers largely insulate covered consumers from the cost of health care decisions. These factors and others contribute to making Medicare a greater and more complex fiscal challenge than even Social Security.

HI's Trust Fund Faces Cash Flow Problems Long before the HI Trust Fund Is Projected to Be Insolvent

Current projections of future HI income and outlays illustrate the timing and severity of Medicare's fiscal challenge. Today, the HI Trust Fund takes in more in taxes than it spends. Largely because of the known demographic trends I have described, this situation will change. Under the Trustees' 2003 intermediate assumptions, program outlays are expected to

begin to exceed program tax revenues in 2013 (see fig. 6). To finance these cash deficits, HI will need to draw on the special-issue Treasury securities acquired during the years of cash surpluses. For HI to “redeem” its securities, the government will need to obtain cash through some combination of increased taxes, spending cuts, and/or increased borrowing from the public (or, if the unified budget is in surplus, less debt reduction than would otherwise have been the case). Neither the decline in the cash surpluses nor the cash deficits will affect the payment of benefits, but the negative cash flow will place increased pressure on the federal budget to raise the resources necessary to meet the program’s ongoing costs. This pressure will only increase when Social Security also experiences negative cash flow and joins HI as a net claimant on the rest of the budget.³

Figure 6: Medicare’s HI Trust Fund Faces Cash Deficits as Baby Boomers Retire



Source: CMS, Office of the Actuary, and GAO.

Note: GAO analysis based on the intermediate assumptions of *The 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

³Under the Trustees’ intermediate 2003 projections, this will occur for Social Security (OASDI) in 2018.

The gap between HI income and costs shows the severity of HI's financing problem over the longer term. This gap can also be expressed relative to taxable payroll (the HI Trust Fund's funding base) over a 75-year period. This year, under the Trustees 2003 intermediate estimates, the 75-year actuarial deficit is projected to be 2.40 percent of taxable payroll—a significant increase from last year's projected deficit of 2.02 percent. This means that to bring the HI Trust Fund into balance over the 75-year period, either program outlays would have to be immediately reduced by 42 percent or program income immediately increased by 71 percent, or some combination of the two. These estimates of what it would take to achieve 75-year trust fund solvency understate the extent of the problem because the program's financial imbalance gets worse in the 76th and subsequent years. Every year that passes we drop a positive year and add a much bigger deficit year.

The projected exhaustion date of the HI Trust Fund is a commonly used indicator of HI's financial condition. Under the Trustees 2003 intermediate estimates, the HI Trust Fund is projected to exhaust its assets in 2026. This solvency indicator provides information about HI's financial condition, but it is not an adequate measure of Medicare's sustainability for several reasons. HI Trust Fund balances do not provide meaningful information on the government's fiscal capacity to pay benefits when program cash inflows fall below program outlays. As I have described, the government would need to come up with cash from other sources to pay for benefits once outlays exceeded program tax income.

In addition, the HI Trust Fund measure provides no information on SMI. SMI's expenditures, which account for about 43 percent of total Medicare spending, are projected to grow even faster than those of HI in the near future. Moreover, Medicare's complex structure and financing arrangements mean that a shift of expenditures from HI to SMI can extend the solvency of the HI Trust Fund, creating the appearance of an improvement in program's financial condition. For example, the Balanced Budget Act of 1997 modified the home health benefit, which resulted in shifting a portion of home health spending from the HI Trust Fund to SMI. Although this shift extended HI Trust Fund solvency, it increased the draw on general revenues and beneficiary SMI premiums while generating little net savings.

Ultimately, the critical question is not how much a trust fund has in assets, but whether the government as a whole and the economy can afford the promised benefits now and in the future and at what cost to other claims on scarce resources. To better monitor and communicate changes in

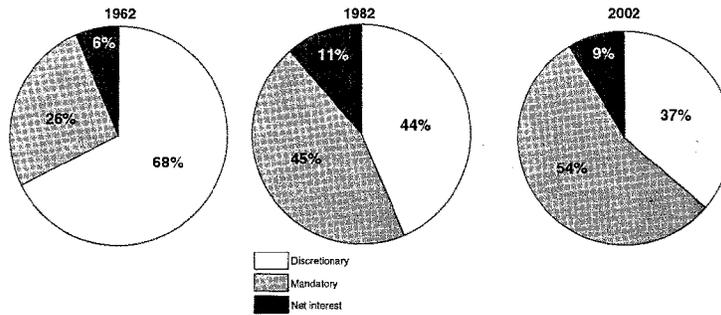
future total program spending, new measures of Medicare's sustainability are needed. As program changes are made, a continued need will exist for measures of program sustainability that can signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues, the percentage of total federal revenues or gross domestic product devoted to Medicare, or program spending per enrollee. As such measures are developed, questions would need to be asked about actions to be taken if projections showed that program expenditures would exceed the chosen level.

Absent Reform of Medicare and Other Entitlements for the Elderly, Budgetary Flexibility Will Disappear

Taken together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from about 12 percent of federal revenues in 2002 to more than one-quarter by midcentury. The budgetary challenge posed by the growth in Medicare becomes even more significant in combination with the expected growth in Medicaid and Social Security spending. This growth in spending on federal entitlements for retirees will become increasingly unsustainable over the longer term, compounding an ongoing decline in budgetary flexibility. Over the past few decades, spending on mandatory programs has consumed an ever-increasing share of the federal budget.⁴ In 1962, prior to the creation of the Medicare and Medicaid programs, spending for mandatory programs plus net interest accounted for about 32 percent of total federal spending. By 2002, this share had almost doubled to approximately 63 percent of the budget. (See fig. 7.)

⁴"Mandatory spending" refers to outlays for entitlement programs such as Food Stamps, Medicare, veterans' pensions, payment of interest on the public debt, and nonentitlements such as payments to states from Forest Service receipts. In 2002 Social Security, Medicare, and Medicaid accounted for over 71 percent of mandatory spending.

Figure 7: Federal Spending for Mandatory and Discretionary Programs, Fiscal Years 1962, 1982, and 2002



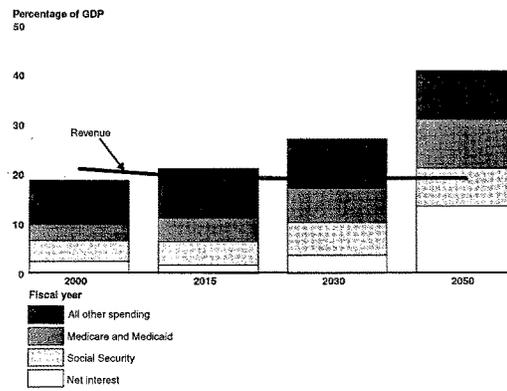
Source: Budget of the United States Government: Fiscal Year 2004, Office of Management and Budget.

In much of the past decade, reductions in defense spending helped accommodate the growth in these entitlement programs. Even before the events of September 11, 2001, however, this ceased to be a viable option. Indeed, spending on defense and homeland security will grow as we seek to combat new threats to our nation's security.

GAO prepares long-term budget simulations that seek to illustrate the likely fiscal consequences of the coming demographic tidal wave and rising health care costs. These simulations continue to show that to move into the future with no changes in federal retirement and health programs is to envision a very different role for the federal government. Assuming, for example, that the tax reductions enacted in 2001 do not sunset and discretionary spending keeps pace with the economy, by midcentury federal revenues may be inadequate to pay Social Security and interest on the federal debt. Spending for the current Medicare program—without any additional new benefits—is projected to account for more than one-quarter of all federal revenues. To obtain budget balance, massive spending cuts, tax increases, or some combination of the two would be necessary. (See fig. 8). Neither slowing the growth of discretionary spending nor allowing the tax reductions to sunset eliminates the

imbalance. In addition, while additional economic growth would help ease our burden, the projected fiscal gap is too great for us to grow our way out of the problem.

Figure 8: Composition of Spending as a Share of GDP Assuming Discretionary Spending Grows with GDP after 2003 and the 2001 Tax Cuts Do Not Sunset



Source: GAO's March 2003 analysis.

Note: Assumes currently scheduled Social Security benefits are paid in full throughout the simulation period. Social Security and Medicare projections are based on the Trustees' 2003 intermediate assumptions.

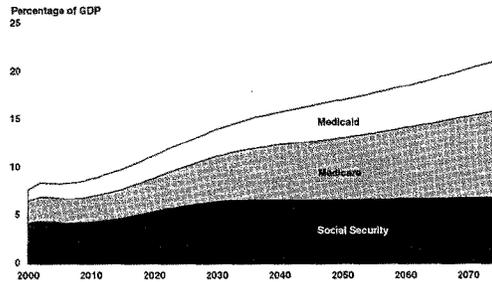
Indeed, long-term budgetary flexibility is about more than Social Security and Medicare. While these programs dominate the long-term outlook, they are not the only federal programs or activities that bind the future. The federal government undertakes a wide range of programs, responsibilities, and activities that obligate it to future spending or create an expectation for spending. Our recent report describes the range and measurement of such fiscal exposures—from explicit liabilities such as environmental cleanup requirements to the more implicit obligations presented by life-

cycle costs of capital acquisition or disaster assistance.⁵ Making government fit the challenges of the future will require not only dealing with the drivers—entitlements for the elderly—but also looking at the range of other federal activities. A fundamental review of what the federal government does and how it does it will be needed.

Medicare Is Projected to Absorb Ever-Increasing Shares of the Economy

At the same time, it is important to look beyond the federal budget to the economy as a whole. Figure 9 shows the total future draw on the economy represented by Medicare, Medicaid, and Social Security. Under the 2003 Trustees' intermediate estimates and the Congressional Budget Office's (CBO) most recent long-term Medicaid estimates, spending for these entitlement programs combined will grow to 14 percent of GDP in 2030 from today's 8.4 percent. Taken together, Social Security, Medicare, and Medicaid represent an unsustainable burden on future generations.

Figure 9: Social Security, Medicare, and Medicaid Spending as a Percentage of GDP



Source: CMS, Office of the Actuary, SSA, Office of the Actuary, CBO and GAO.
 Note: Projections based on the intermediate assumptions of the 2003 Trustees' Reports, CBO's March 2003 short-term Medicaid estimates, and CBO's June 2002 Medicaid long-term projections under midrange assumptions.

⁵U.S. General Accounting Office, *Fiscal Exposures: Improving the Budgetary Focus on Long-Term Costs and Uncertainties*, GAO-03-213 (Washington, D.C.: Jan. 24, 2003).

Although real incomes are projected to continue to rise, they are expected to grow more slowly than has historically been the case. At the same time, the demographic trends and projected rates of growth in health care spending I have described will mean rapid growth in entitlement spending. Taken together, these projections raise serious questions about the capacity of the relatively smaller number of future workers to absorb the rapidly escalating costs of these programs.

As HI trust fund assets are redeemed to pay Medicare benefits and SMI expenditures continue to grow, the program will constitute a claim on real resources in the future. As a result, taking action now to increase the future pool of resources is important. To echo Federal Reserve Chairman Alan Greenspan, the crucial issue of saving in our economy relates to our ability to build an adequate capital stock to produce enough goods and services in the future to accommodate both retirees and workers in the future.⁶ The most direct way the federal government can raise national saving is by increasing government saving, that is, as the economy returns to a higher growth path, a balanced fiscal policy that recognizes our long-term challenges can help provide a strong foundation for economic growth and can enhance our future budgetary flexibility. It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Putting Medicare on a sustainable path for the future would help fulfill this generation's stewardship responsibility to succeeding generations. It would also help to preserve some capacity for future generations to make their own choices for what role they want the federal government to play.

As with Social Security, both sustainability and solvency considerations drive us to address Medicare's fiscal challenges sooner rather than later. HI Trust Fund exhaustion may be more than 20 years away, but the squeeze on the federal budget will begin as the baby boom generation begins to retire. This will begin as early as 2008, when the leading edge of the baby boom generation becomes eligible for early retirement.⁷ CBO's current 10-year budget and economic outlook reflects this. CBO projects that economic growth will slow from an average of 3.2 percent a year from 2005 through 2008 to 2.7 percent from 2009 through 2013 reflecting slower

⁶Testimony before the Senate Committee on Banking, Housing, and Urban Affairs, July 24, 2001.

⁷In 2008 the first baby boomers will reach age 62 and become eligible for Social Security benefits; in 2011, they will reach age 65 and become eligible for Medicare benefits.

labor force growth. At the same time, annual rates of growth in entitlement spending will begin to rise. Annual growth in Social Security outlays is projected to accelerate from 5.2 percent in 2007 to 6.6 percent in 2013. Annual growth in Medicare enrollees is expected to accelerate from 1.1 percent today to 2.9 percent in 2013. Acting sooner rather than later is essential to ease future fiscal pressures and also provide a more reasonable planning horizon for future retirees. We are now at a critical juncture. In less than a decade, the profound demographic shift that is a certainty will have begun.

**Pressure to Address
Medicare Coverage
Gaps Must Be
Balanced against
Program
Sustainability
Concerns**

Despite a common awareness of Medicare's current and future fiscal plight, pressure has been building to address recognized gaps in Medicare coverage, especially the lack of a prescription drug benefit and protection against financially devastating medical costs. Filling these gaps could add massive expenses to an already fiscally overburdened program. Under the Trustees 2003 intermediate assumptions, the present value of HI's actuarial deficit is \$6.2 trillion.⁴ This difficult situation argues for tackling the greatest needs first and for making any benefit additions part of a larger structural reform effort.

The Medicare benefit package, largely designed in 1965, provides virtually no outpatient drug coverage. Beneficiaries may fill this coverage gap in various ways. All beneficiaries have the option to purchase supplemental policies—Medigap—when they first become eligible for Medicare at age 65. Those policies that include drug coverage tend to be expensive and provide only limited benefits. Some beneficiaries have access to coverage through employer-sponsored policies or private health plans that contract to serve Medicare beneficiaries. In recent years, coverage through these sources has become more expensive and less widely available. Beneficiaries whose income falls below certain thresholds may qualify for Medicaid or other public programs. According to one survey, in the fall of

⁴This estimate represents the present value of HI's future expenditures less future tax income, taking into account the amount of HI trust fund assets at hand at the beginning of the projection period and adjusting for the ending target trust fund balance. Excluding the ending target trust fund balance, HI's unfunded obligation is estimated to be \$5.9 trillion over the 75-year period under the Trustees 2003 intermediate assumptions.

1999, more than one-third of beneficiaries reported that they lacked drug coverage altogether.⁹

Medicare also does not limit beneficiaries' cost-sharing liability. The average beneficiary who obtained services had a total liability for Medicare-covered services of \$1,700, consisting of \$1,154 in Medicare copayments and deductibles in addition to the \$546 in annual part B premiums in 1999, the most recent year for which data are available on the distribution of these costs. The burden can, however, be much higher for beneficiaries with extensive health care needs. In 1999, about 1 million beneficiaries were liable for more than \$5,000, and about 260,000 were liable for more than \$10,000 for covered services. In contrast, employer-sponsored health plans for active workers typically limited maximum annual out-of-pocket costs for covered services to less than \$2,000 per year for single coverage.¹⁰

Modernizing Medicare's benefit package will require balancing competing concerns about program sustainability, federal obligations, and the hardship faced by some beneficiaries. In particular, the addition of a benefit that has the potential to be extremely expensive—such as prescription drug coverage—should be focused on meeting the needs deemed to be of the highest priority. This would entail targeting financial help to beneficiaries most in need—those with catastrophic drug costs or low incomes—and, to the extent possible, avoiding the substitution of public for private insurance coverage. As I continue to maintain, acting prudently means making any benefit expansions in the context of overall program reforms that are designed to make the program more sustainable over the long term instead of worsening the program's financial future.

One reform to help improve Medicare's financial future would be to modify Medicare's cost-sharing rules and provide beneficiaries with better incentives to use care appropriately. Health insurers today commonly design cost-sharing requirements—in the form of deductibles, coinsurance, and copayments—to ensure that enrollees are aware that

⁹Mary A. Laschober and others, "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996 to 1999," *Health Affairs Web Exclusive* (Bethesda, Md: Project Hope, Feb. 27, 2002). http://www.healthaffairs.org/1130_abstract_e.php?ID=http://www.healthaffairs.org/Library/v21n2/s4.pdf (downloaded Mar. 19, 2003).

¹⁰The Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2000 Annual Survey* (Menlo Park, Calif. and Chicago: 2000).

there is a cost associated with the provision of services and to use them prudently. Ideally, cost-sharing should encourage beneficiaries to evaluate the need for discretionary care but not discourage necessary care. Coinsurance or copayments would be required generally for services considered to be discretionary and potentially overused and would aim to steer patients to lower cost or better treatment options. Care must be taken, however, to avoid setting cost-sharing requirements so high as to create financial barriers to care.

Medicare fee-for-service cost-sharing rules diverge from these common insurance industry practices in important ways. For example, Medicare imposes a relatively high deductible of \$840 for hospital admissions, which are rarely optional. In contrast, Medicare has not increased the part B deductible since 1991. For the last 12 years, the deductible has remained constant at \$100 and has thus steadily declined as a proportion of beneficiaries' real incomes. Adjusted for inflation, the deductible has fallen to \$74.39 in 1991 dollars.

Medicare Reforms Should Realign Incentives, Improve Transparency, and Strengthen Accountability

In recent years, leading proposals have been made to restructure Medicare that have included greater reliance on private health plans and reforms to the traditional fee-for-service program. The weaknesses identified in these two components of the current program suggest several lessons regarding such restructuring. Experience with Medicare's private health plan alternative, called Medicare+Choice, suggests that details matter if competition is to produce enhanced benefits for enrollees and savings for the program. In addition, the traditional program must not be left unattended because it will be an important part of Medicare for years to come. The strategies needed to address either structural component must incorporate sufficient incentives to achieve efficiency, adequate transparency to reveal the cost of health care, and appropriate accountability mechanisms to ensure that the promised care and level of quality are actually delivered.

Reforms That Include Private Plans Should Incorporate Incentives Sufficient to Result in Program Savings

If the inclusion of private health plans is to produce savings for Medicare, private incentives and public goals must be properly aligned. This means designing a program that will encourage beneficiaries to select health plan options most likely to generate program savings. This is not the case in the current Medicare+Choice program. For example, incentives for health plan efficiency exist, but any efficiency gains achieved do not produce Medicare savings. Payments to private health plans that participate in Medicare+Choice are not set through a competitive process. Instead, plans

receive a fixed payment from Medicare as prescribed by statute and in return must provide all Medicare-covered services with the exception of hospice. Efficient health plans are better able to afford to provide extra benefits, such as outpatient prescription drug benefits; charge a lower monthly premium; or both and may do so to attract beneficiaries and increase market share. Until recently, however, these efficiency and market share gains were advantageous to beneficiaries and health plans but generated no savings for Medicare. Even today, the opportunity for the program to realize savings from competition among Medicare+Choice health plans remains extremely limited.¹¹ This experience has shown that savings are not automatic from simply enrolling beneficiaries in private health plans.

The Medicare+Choice experience offers another lesson about private plans and program savings. That is, as we recommended in 1998, payments to health plans must be adequately risk-adjusted for the expected health care costs of the beneficiaries they enroll. Otherwise, the government can inadequately compensate health plans that enroll less healthy beneficiaries with higher expected health care costs or will overpay health plans that enroll relatively healthy beneficiaries with low expected health care costs. Moreover, health plans will have an incentive to avoid enrolling less healthy beneficiaries with higher expected health care costs. In 2000, we reported that the failure to adequately adjust Medicare's payments to private health plans for beneficiaries' expected health care costs unnecessarily increased Medicare spending by \$3.2 billion in 1998.¹²

A third lesson is that the use of private plans to serve Medicare beneficiaries may not be feasible in all locations nationwide. In Medicare+Choice, it has been difficult and expensive to encourage private

¹¹Beginning in 2003, Medicare health plans may, in effect, rebate to beneficiaries some, or all, of Medicare's \$58.70 monthly part B premium. Both beneficiaries and the government benefit if health plans use this option to compete because, for every \$1 reduction in health care premiums, the health plans must return \$0.25 to the government. If a health plan rebates the entire part B premium, the government saves \$14.68 per beneficiary per month. Currently, five Medicare+Choice health plans in eight counties rebate at least a portion of the part B premium. In 2003, Medicare began pilot testing an arrangement for sharing financial risk with preferred provider organizations that enroll program beneficiaries. As of March 2003, there were 56,677 enrollees in these preferred provider organizations.

¹²See U.S. General Accounting Office, *Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending*, GAO/HEHS-00-161 (Washington, D.C.: Aug. 23, 2000). CMS has since begun to phase in a payment adjustment system that is designed to help prevent some of these excess payments.

health plans to serve rural areas. Payment rates have been substantially raised in rural areas since 1997, yet by 2003 nearly 40 percent of beneficiaries living in rural areas lack access to a private health plan; in contrast, 15 percent of beneficiaries in urban areas lack access to a plan. Finally, the Medicare+Choice experience underscores the importance of beneficiaries having user-friendly, accurate information to compare their health plan options and of holding private health plans appropriately accountable for the services they have promised to deliver.

Fixing Flaws In Traditional Medicare Essential to Alter Program's Fiscal Course

Leading Medicare reform proposals have included traditional Medicare as a component in their design. Traditional Medicare is likely to have a significant role for years to come, as any fundamental structural reforms would take considerable time before plan and beneficiary participation becomes extensive. Therefore, addressing flaws in the traditional program should be part of any plan to steer Medicare away from insolvency and improve its sustainability for future generations. The experience of other health insurers' use of cost-containment strategies, including some incentives for beneficiaries to make value-based choices, suggests a strategy for modernizing the program's design. In the current program, the lack of insurance-type protections and difficulty in setting payment rates keep Medicare from achieving greater efficiencies and thus from improving its balance sheet.

Supplemental Coverage Reduces Beneficiary Cost Sensitivity

Coverage through Medigap—policies that meet federally established standards and are sold by private insurers—helps to fill in some of Medicare's gaps, but Medigap plans also have shortcomings. As required by law, Medigap plans must conform to 1 of 10 standard benefit packages, which vary in levels of coverage. Medigap offers beneficiaries stop-loss protections that are lacking in traditional Medicare, but these policies diminish important program protections by covering required deductibles and coinsurance. The most popular Medigap plans are fundamentally different from employer-sponsored health insurance policies for retirees in that they do not require individuals to pay deductibles, coinsurance, and copayments. Such cost-sharing requirements are intended to make beneficiaries aware of the costs associated with the use of services and encourage them to use these services prudently. In contrast, Medigap's first-dollar coverage—the elimination of deductibles or coinsurance associated with the use of covered services—undermines this objective. Although such coverage reduces financial barriers to health care, it diminishes beneficiaries' sensitivity to costs and likely increases beneficiaries' use of services, adding to total Medicare spending.

Difficulties in Setting Payment Rates

Traditional Medicare needs the tools that other insurers use to achieve better value for the protection provided. Instead of working at cross-purposes to the traditional program, Medigap should be better coordinated with it. Insurance-type reforms to Medicare and Medigap—namely, the preservation of cost-sharing requirements in conjunction with stop-loss provisions—could help improve beneficiaries' sensitivity to the cost of care while better protecting them against financially devastating medical costs.

Medicare too often pays overly generous rates for certain services and products, preventing the program from achieving a desirable degree of efficiency. For example, for certain services, our work has shown substantially higher Medicare payments relative to providers' costs—35 percent higher for home health care in the first six months of 2001 and 19 percent higher for skilled nursing facility care in 2000.¹³ Similarly, Medicare has overpaid for various medical products. Last year, we reported that, in 2000, Medicare paid over \$1 billion more than other purchasers for certain outpatient drugs that the program covers. Earlier findings that have since been addressed by the Congress following our recommendations showed Medicare paying over \$500 million more than another public payer for home oxygen equipment. Excessive payments hurt not only the taxpayers but also the program's beneficiaries or their supplemental insurers, as beneficiaries are liable for copayments equal to 20 percent of Medicare's approved fee. For certain outpatient drugs, Medicare's payments to providers were so high that the beneficiaries' copayments exceeded the price at which providers could buy the drugs. In 2001, we recommended that, for covered outpatient prescription drugs, Medicare establish payment levels more closely related to actual market transaction costs, using information available to other public programs that pay at lower rates.

Over the past two decades, at the Congress' direction, Medicare has implemented a series of payment reforms designed to promote the efficient delivery of services and control program spending. Some reforms required establishing set fees for individual services; others required paying a fixed amount for a bundle of services. The payment methods

¹³See U.S. General Accounting Office, *Medicare Home Health Care: Payments to Home Health Agencies Are Considerably Higher than Costs*, GAO-02-663 (Washington, D.C. May 6, 2002) and U.S. General Accounting Office, *Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities*, GAO-03-183 (Washington, D.C. Dec. 31, 2002).

introduced during this time were designed to include—in addition to incentives for efficiencies—a means to calibrate payments to ensure beneficiary access and fairness to providers.

A major challenge in administering these methods—whether based on fee schedules or prospective payment systems using bundled payments—involves adjusting the payments to better account for differences in patients' needs and providers' local markets to ensure that the program is paying appropriately and adequately. Payment rates that are too low can impair beneficiary access to services and products, while rates that are too high add unnecessary financial burdens to the program. As a practical matter, Medicare is often precluded from using market forces—that is, competition—to determine appropriate rates. In many cases, Medicare's size and potential to distort market prices makes it necessary to use means other than competition to set a price on services and products.

Most of Medicare's rate-setting methods are based on formulas that use historical data on providers' costs and charges. Too often, these data are not recent or comprehensive enough to measure the costs incurred by efficient providers. At the same time, data reflecting beneficiaries' access to services are also lacking. When providers contend that payments are not adequate, typically information is not readily available to provide the analytical support needed to determine whether these claims are valid. I have noted in the past the essential need to monitor the impact of program policy changes so that distinguishing between desirable and undesirable consequences can be done systematically and in a timely manner. To that end, I have also noted the importance of investing adequate resources in the agency that runs Medicare to ensure that the capacity exists to carry out these policy-monitoring activities.

Under some circumstances, competition may be feasible and practical for setting more appropriate rates. Medicare has pilot tested "competitive bidding" in a few small markets. According to program officials, these test projects have shown that, for selected medical products, Medicare has saved money on items priced competitively. As part of these competitive bidding tests, steps were taken to monitor beneficiary access and product quality. To use competitive bidding on a broader scale, Medicare would require not only new authority but would need to make substantial administrative preparations, as competing with a larger number of products nationally would entail bidding in multiple markets and monitoring access and quality once prices had been set.

**Concluding
Observations**

Medicare's financial challenge is very real. The 21st century has arrived and the demographic tidal wave is on the horizon. Within 5 years, individuals in the vanguard of the baby boom generation will be eligible for Social Security and 3 years after that they will be eligible for Medicare. The future costs of serving the baby boomers are already becoming a factor in CBO's short-term cost projections.

Clearly the issue before us is not whether to reform Medicare but how. I feel the greatest risk lies in doing nothing to improve Medicare's long-term sustainability. It is my hope that we will think about the unprecedented challenge of facing future generations in our aging society. Engaging in a comprehensive effort to reform the program and put it on a sustainable path for the future would help fulfill this generation's stewardship responsibility to succeeding generations.

Medicare reform would be done best with considerable lead time to phase in changes and before the changes that are needed become dramatic and disruptive. Given the size of Medicare's financial challenge, it is only realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. We should begin this now, when retirees are still a far smaller proportion of the population than they will be in the future. The sooner we get started, the less difficult the task will be.

As we contemplate the forecast for Medicare's fiscal condition and its implications, we must also remember that the sources of some of its problems—and its solutions—are outside the program and are universal to all health care payers. Some tax preferences mask the full cost of providing health benefits and can work at cross-purposes to the goal of moderating health care spending. Therefore, it may be important to reexamine the incentives contained in current tax policy and consider potential reforms. Advances in medical technology are also likely to keep raising the price tag of providing care, regardless of the payer. Although technological advances unquestionably provide medical benefits, judging the value of those benefits—and weighing them against the additional costs—is more difficult. Consumers are not as informed about the cost of health care and its quality as they may be about other goods and services. Thus, while the greater use of market forces may help to control cost growth, it will undoubtedly be necessary to employ other cost control methods as well.

We must also be mindful that health care costs compete with other legitimate priorities in the federal budget, and their projected growth threatens to crowd out future generations' flexibility to decide which

competing priorities will be met. 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.

A major challenge policymakers face in considering health care reforms is the dearth of timely, accurate information with which to make decisions. Medicare's size and impact on the nation's health care economy means that its payment methods and rate adjustments, no matter how reasonable, often produce opposition. Recent experience with the payment reforms established in the BBA illustrates this point. In essence, these reforms changed Medicare's payment methods to establish incentives for providers to deliver care efficiently. BBA's changes were enacted in response to continuing rapid growth in Medicare spending that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. Nonetheless, affected provider groups conducted a swift, intense campaign to roll back the BBA changes. In the absence of solid, data-driven analyses, affected providers' anecdotes were used to support contentions that Medicare payment changes were extreme and threatened their financial viability. This and similar reactions to mandated Medicare payment reforms underscore how difficult it is, without prompt and credible data, to defend against claims that payments changes have resulted in insufficient compensation that could lead to access problems.

The public sector can play an important role in educating the nation about the limits of public support. Currently, there is a wide gap between what patients and providers expect and what public programs are able to deliver. Moreover, there is insufficient understanding about the terms and conditions under which health care coverage is actually provided by the nation's public and private payers. In this regard, GAO is preparing a health care framework that includes a set of principles to help policymakers in their efforts to assess various health financing reform options. This framework will examine health care issues systemwide and identify the interconnections between public programs that finance health care and the private insurance market. The framework can serve as a tool for defining policy goals and ensuring the use of consistent criteria for evaluating changes. By facilitating debate, the framework can encourage acceptance of changes necessary to put us on a path to fiscal

sustainability. I fear that if we do not make such changes and adopt meaningful reforms, future generations will enjoy little flexibility to fund discretionary programs or make other valuable policy choices.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other committee members may have.

**Contacts and
Acknowledgments**

For future contacts regarding this testimony, please call William J. Scanlon, Director, Health Care Issues, at (202) 512-7114. Other individuals who made key contributions include Linda Baker, James Cosgrove, Jessica Farb, Hannah Fein, James McFigue, Yorick F. Uzes, and Melissa Wolf.

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CBO TESTIMONY

**Statement of
Douglas Holtz-Eakin
Director**

Medicare's Long-Term Financial Condition

**before the
Joint Economic Committee
Congress of the United States**

April 10, 2003

This statement is embargoed until 10:30 a.m. (EDT), Thursday, April 10, 2003. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.



**CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515**

Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss the future of the Medicare program with you. Medicare is the federal government's largest health care financing program and, with projected outlays of \$277 billion this year, the second largest federal program overall after Social Security. It is the principal payer of medical bills for some 40 million elderly and disabled people, with payments per enrollee currently averaging \$7,000 a year.

Because the issues that the Medicare program will soon face are not exclusive to it, they are best understood when evaluated in the context of society's aging, the rising costs of health care generally, and the long-range financial strains that in coming decades will affect the federal government as a whole. If the program continues to operate as it is currently structured, its costs will rise significantly—even in the absence of program expansions such as a prescription drug benefit. As a consequence, Medicare will necessarily compete with other spending priorities for a much greater share of the federal budget or with private-sector spending for a bigger share of the national economy—or with both.

In light of that outlook, any approach to Medicare should incorporate two features: a recognition of the larger economic and budgetary trade-offs, and consideration of the program structure that would best support Medicare's overall objective of providing financing for high-quality medical care for the elderly and disabled. With regard to economic and budgetary trade-offs, two issues stand out. First, to the extent that the U.S. economy grows at a healthy pace, it will be better able to meet the Medicare population's demands for health care. Put differently, the overall level of national income available in the future constitutes the reservoir from which the resources for both private needs and public programs will be drawn, and the nation must endeavor to enlarge that reservoir to the greatest degree possible in making public policy. Second, the potential pressures on the federal budget from Medicare and other sources will necessitate trade-offs with other spending priorities if federal programs are to absorb no more than their historical fraction of national income.

Alternatively, public policy may steer a course toward devoting a larger fraction of the federal budget and the economy as a whole to Medicare. Even if that is so, it will be desirable to utilize those Medicare funds as efficiently as possible—to purchase the highest-value care with each dollar. Medicare beneficiaries (or their families), together with their providers, are best positioned to guide the use of additional dollars and to choose services that meet therapeutic demands and match individual tastes. Providing those parties with a broader range of choices and improved information, and ensuring their sensitivity to the cost of those services, should facilitate better decisionmaking. At the same time, an appropriate balance must be struck between

providing stronger financial signals to beneficiaries about the cost of their care and providing protection against greater financial exposure.

Improved decisionmaking offers the potential for dynamic consequences as well. Technological advances have historically been a big driver of cost growth in health care services. Subjecting health care innovation to the test of whether a new service, device, or procedure is “worth it” in the view of beneficiaries and their doctors may bring improved discipline to the innovation process.

Finally, as a matter of perspective, I would note that Medicare spending constitutes 17 percent of national expenditures for health care. Accordingly, any effort to ensure that Medicare emphasizes obtaining the highest quality of care per dollar of spending will be more effective if it is undertaken in the context of comparable efforts in the health care sector as a whole.

DEMOGRAPHIC TRENDS

The trustees of the Medicare and Social Security programs estimate that the number of people ages 65 and older could more than double over the coming decades, rising from 37 million today to 70 million in 2030 and 82 million in 2050. That increase is part of a great change in the structure of the U.S. population. Looking at the 20-year period ending in 2010, if the current projections hold, the number of workers in the economy will have grown by more than 33 million; yet the number of people ages 65 and older will have grown by only 8.3 million, or roughly one-quarter as much. In contrast, for the subsequent period, 2010 to 2030—when the baby-boom generation will retire—the number of workers is projected to grow by 14.4 million, whereas the population ages 65 and older is expected to grow by 30 million, or about twice as much.

The consequence of those diverging patterns is that the ratio of the population ages 65 and older to the population in its prime working years—people ages 20 to 64—is projected to grow from 21 percent today to 35 percent in 2030 and 42 percent in 2075. In other words, although the shift to an older society starts with the baby boomers, it persists after they have retired, making the changes more than just a temporary bulge.

That projected demographic shift rests heavily on assumptions about longevity, birth rates, immigration, retirement patterns, and other factors. Although based on past trends and recent experience, all of those assumptions are subject to varying degrees

of uncertainty. Major breakthroughs in medical science could further extend life expectancy, immigration could continue its upward track or be curbed by security concerns, and people could choose to work longer or spend more of their advanced years in partial employment. Without question, considerable uncertainty surrounds any 75-year projection.

Nonetheless, a substantial portion of the coming demographic shift is already in place. The post-World War II baby boom and the 1970s “baby trough” are historical events; the subsequent uptick in birth rates has not been substantial and may now have leveled off; and life expectancy continues to increase. Indeed, the Medicare trustees project that life expectancy for the Medicare population will rise by one year for every 15 years in their 75-year projection period.

HEALTH CARE TRENDS

Nationally, health care expenditures as a percentage of gross domestic product (GDP) have more than doubled over the past several decades, growing from 7.0 percent in 1970 to 14.8 percent in 2002. At the federal level, with Medicare and Medicaid in the forefront, health care expenditures have risen from 1.7 percent of GDP in 1970 to 4.7 percent in 2002, and their share of federal outlays has risen from 9 percent to 24 percent.

On a per capita basis, national spending on health care has increased from \$1,321 in 1970 (in 2002 dollars) to \$5,366 in 2002, or an average of about 4.5 percent per year. The major factor contributing to the growth of real (inflation-adjusted) per capita health care spending has been the development and diffusion of new medical technology. Other factors include expansions in insurance coverage, rising income, medical price inflation in excess of general inflation, and the aging of the population.

In recent years, spending for prescription drugs has grown more rapidly than other health care spending. In real terms, from 1990 to 2002, per capita spending for prescription drugs increased at an average annual rate of about 9 percent, compared with about 3 percent for all other health expenditures. (In contrast, during the 1970-1990 period, spending for prescription drugs grew more slowly than all other health expenditures.) Despite the recent rapid increase in prescription drug spending, it currently accounts for only about 10 percent of all national health expenditures.

In general, new technology changes the pattern of use of medical services, leading to increases in utilization for some services and decreases for others. In other sectors of

the economy, technological advances have often served to reduce costs. On balance, however, research has found that medical innovation has led both to increases in health care expenditures and, frequently, to improvements in the treatment of medical conditions.

With respect to pharmaceuticals, Congressional Budget Office (CBO) analysts continue to monitor the available evidence on the extent to which spending for prescription drugs might be offset by savings in other categories of health care costs (such as hospitals, physicians, and nursing homes). Existing research provides little insight into the overall effect of changes in prescription drug coverage. Several studies have suggested that giving specific drugs to particular classes of patients will reduce their spending for other health services, but it is unclear whether those results can be applied to the general population. More broadly, determining what health care spending would have been in the absence of increased drug use presents substantial methodological challenges.

Whether measured in total or on a per capita basis, both government-financed and private-sector health care costs have grown rapidly over the past 30 years, outpacing the economy's growth rate. Comparing cost growth in the private sector and in the Medicare program can be difficult because of the differences in the populations covered and the benefits provided—particularly as those components change over time; as a result, even well-structured comparisons have shown differing rates of growth for periods of several years. Over the longer term, however, the data show roughly comparable growth rates for total health care costs for Medicare and the private sector (reflecting, in part, past legislative action aimed at bringing Medicare payments in line with market-based rates).

MEDICARE TRENDS

From 1970 to 2002, Medicare costs after adjusting for inflation increased more than eightfold. As a share of GDP, they rose from 0.7 percent in 1970 to 2.5 percent in 2002 (based on CBO's revised estimates). Although cost growth on a per-enrollee basis was volatile, it, too, generally rose by much more than the economy. Over the 1970-2002 period, real costs per enrollee grew at approximately the rate of per capita GDP plus 2.8 percentage points—or more than twice the economy's growth rate.

The major elements in the Medicare program's overall rise in costs have been increased enrollment (from 20 million beneficiaries in 1970 to 40 million this year) and the same factors that have led to increases in health care spending in the nation as a

whole—most notably, the development and diffusion of new medical technology. Other contributors to cost growth have been program expansions as a result of legislative and administrative changes.

In dollar terms, inpatient hospital care accounts for the largest portion of the Medicare program's growth. Expenditures for skilled nursing care and home health services, though constituting only 5 percent each of current program spending, have grown particularly rapidly. Real spending for those services increased at an average annual rate of about 12 percent from 1975 to 2001, compared with an average annual rate of about 7 percent for total Medicare spending.

HOW BIG IS THE PROBLEM?

The convergence of an aging society and rapidly rising health care costs portends a very large long-term escalation of Medicare spending. For more than two decades, the program's trustees have consistently projected long-range financing shortfalls and eventual insolvency of the larger of the two parts of Medicare, the Hospital Insurance (HI) trust fund. In the trustees' latest report, the HI trust fund is projected to be depleted by 2026; over the next 75 years as a whole, the program would need 71 percent more resources than those provided under current law. In the 75th year, it would need over 200 percent more—under current law, its receipts would equal 3.4 percent of taxable payroll while its expenditures would equal 11.2 percent.

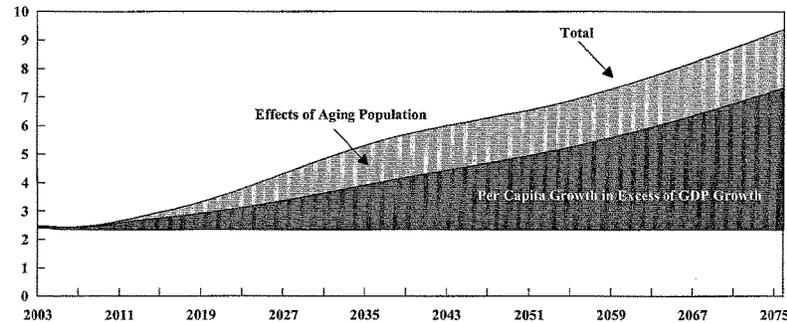
The impact of the demographic shift is clearly illustrated by the trustees' projection of a decreasing number of workers per HI beneficiary. In 1970, there were 4.6 workers for every recipient; today, there are 3.7. The trustees project that in 2030 and 2075, there will be 2.4 and 2.0 workers, respectively, per beneficiary.

Important as these reports are, the trustees' projections and "trust fund accounting" tell only part of the story of the program's impact on federal budgetary resources and the economy in general. Trust funds are bookkeeping devices. As such, the Medicare trust funds provide spending authority for the Treasury Department to make payments, but they do not generate the actual resources needed to make those payments. Much of what is credited to trust fund accounts comes from payments or contributions from the government's general fund—transactions that are simply internal bookkeeping entries by the Treasury.

More important, the trustees' traditional measures of insolvency are not measures of the program's impact on the economy. The best example of that is reflected in the

Figure 1.
Projected Long-Term Growth of Medicare Spending

(As a percentage of GDP)



Source: Congressional Budget Office.

financing of the Supplementary Medical Insurance (SMI) part of Medicare, three-quarters of which comprises general fund contributions that are intended to cover costs not met by enrollees' premiums. Under those financing provisions, it is technically infeasible for SMI to be projected insolvent, despite the fact that its costs are projected to rise from 1 percent of GDP today to 4.2 percent in 2075, a faster rate of growth than that projected for HI.

To put the long-term outlook in a broader economic framework, CBO has projected the cost of Medicare as a share of GDP to show how much of the nation's production of goods and services it estimates will be used to pay for the program. Using its recent baseline budget assumptions for the next 10 years and those of the Medicare trustees for the subsequent long-range period (to 2075) as a base case, CBO estimates that Medicare's costs will rise from 2.5 percent of GDP in 2002 to 9.2 percent in 2075 (see Figure 1). Approximately 30 percent of that growth is due to society's aging; the remaining 70 percent is attributable to general growth in health care costs in excess of the rate of GDP growth.

Another way of looking at that growth is to consider it in today's context. If the Medicare program's costs *today* accounted for 9.2 percent of GDP, they would equal

half of what is now spent under the entire federal budget. If the program's higher costs were added to what is now expended, total federal receipts (which currently absorb about 18 percent of GDP) would have to be one-third larger. And if those increased costs were paid for entirely through a payroll-based tax, the rate now set at 15.3 percent on the earnings of most workers would have to more than double—a rise equal to roughly \$6,000 per worker (that is, \$3,000 each for the worker and his or her employer).

RISKS TO THE OUTLOOK

The most significant aspect of those projections is that annual growth of per capita Medicare spending is expected to increase faster than GDP but less quickly than in the past. CBO's base-case projection assumes that per capita Medicare spending will eventually rise 1 percentage point faster than the growth of GDP—a rate substantially slower than the 2.8 percentage-point “excess cost” rate that the program has experienced over the past 32 years. CBO's assumption of an eventual deceleration in the relative rise of health care costs is consistent with that of the Medicare trustees (as well as others). But that assumption might be too optimistic, and even small variances from it could have significant economic implications when costs are projected over long periods.

For example, if CBO's long-range projection had incorporated an excess-cost rate for Medicare that was 0.5 percentage points faster than was assumed in the base case, Medicare expenditures would be projected to grow to 5.4 percent of GDP in 2030 and 13.2 percent in 2075, compared with the base-case projections of 4.7 percent and 9.2 percent. Alternatively, if the growth rate was pegged to rise by 0.5 percent less than in the base case, Medicare spending would still reach 6.4 percent of GDP in 2075, or more than two and a half times its current share. Both assumptions imply much higher relative costs than those Medicare incurs today, but the spread of nearly 7 percent (of GDP) between the two estimates provides some perspective on the uncertainty surrounding the program's eventual share of the economy.

Adding to that uncertainty is the potential for program expansions. Enacting a new prescription drug benefit, easing existing limits on payments to providers, and possibly expanding long-term care coverage would exacerbate both the rising long-range spending trajectory and the risks associated with the long-term outlook.

A FRAMEWORK FOR POLICY ANALYSIS

Ultimately, the costs of Medicare, other forms of future retirement income and services, and consumption for the working-age population will be drawn from the economy. The larger it is, the more easily retirement-related costs can be covered without cramping the lifestyles of workers. In that light, it would be beneficial to structure policies, to the extent possible, to minimize incentives for people to consume more at the expense of resources for investment. Medicare and related federal entitlement programs are heavily oriented toward consumption, and as their costs rise, they generate pressures at odds with the savings and investment that constitute the core of economic growth. Program expansions by themselves would only increase the extent to which those pressures impinged on faster economic growth. If major changes to Medicare's benefits are to be undertaken, both their value to program recipients and the strains they will place on the economy must be considered.

The most effective approaches to constraining Medicare costs in the future—and to getting the greatest improvement in health for the money that is spent—are likely to be those that give beneficiaries and health care providers appropriate incentives to spend federal funds wisely. In particular, beneficiaries should have as many choices among providers and health plans as are feasible, but they should also be aware of and be sensitive to the consequences of those choices. Because Medicare—for all its massive size—constitutes only about 17 percent of national outlays for health care, efforts to improve its efficiency would stand a greater chance of success if they were generally consistent with the directions being taken in the larger health care system.

POLICY OPTIONS: THE FUNDAMENTAL CHOICES ARE DIFFICULT

Medicare is a popular program, so options to relieve these long-term fiscal pressures require difficult choices. Garnering public support to cut or constrain the program's growth is difficult. Even in the face of the long-term fiscal strains described here, the momentum of late has been for program expansion. Taxes could be boosted, but doing so could impair economic growth, and if taxes were the sole means used to pay for Medicare, the resulting increase would be large.

CBO has estimated the long-term impact of two measures to constrain the program's growth (see Table 1). Gradually raising Medicare's eligibility age from 65 to 70 would adjust the program to reflect past and projected increases in longevity. On the basis of average longevity at the time, new retirees in 1970 could expect 16 years of

Table 1.
Effects of Illustrative Options for Reducing Growth of Net Medicare Spending

(As a percentage of GDP)	2002	2030	2050	2075
Raise the Eligibility Age to 70	n.a.	-0.2	-0.6	-0.7
Collect 50 Percent of SMI Costs from Enrollees	n.a.	-0.6	-0.7	-1.0
Memorandum:				
Projected Gross Medicare Spending Under Current Policies	2.5	4.7	6.5	9.2
Less: SMI Premiums	0.3	0.6	0.7	1.0
Projected Net Medicare Spending Under Current Policies	2.2	4.2	5.8	8.2

Source: Congressional Budget Office based on its January 2003 baseline budget projections and the 2002 report of the Medicare trustees.
 Notes: SMI = Supplementary Medical Insurance (Part B of Medicare); n.a. = not applicable.

The effects of each illustrative option are considered in isolation; if implemented together, the options would interact in ways that would reduce the combined savings.

Medicare coverage. Today, new enrollees can expect 18 years of coverage. On the basis of current projections, those enrolling in 2030 will be able to expect nearly 20 years. Such a change in the age of eligibility would constrain the program's long-term spending trajectory and produce savings equal to 0.7 percent of GDP in 2075. Medicare's overall costs would nevertheless climb from 2.5 percent of GDP in 2002 to 8.5 percent of GDP in 2075.

Doubling the SMI premium would similarly recognize and adjust for the increase in lifetime benefits as well as return the enrollee's responsibility for that program's financing to its original 50/50 split with the federal government. (Today, enrollees' premiums cover only 25 percent of SMI's costs.) This change would produce program savings equal to 1 percent of GDP in 2075.

Although the options noted above seemingly constitute major reforms of Medicare, they would merely temper the rising program costs now projected. Even if measures were enacted that cut in half the projected rate of excess cost growth in Medicare, the program's eventual share of GDP would still more than double, rising to 6.4 percent in 2075.

Other approaches would raise beneficiaries' cost sharing for services, reduce providers' payments, employ disease management and case management, and introduce greater competition to the Medicare market. For example, one alternative would limit what Medicare contributes toward health care expenses. A defined contribution could strengthen consumers' and providers' incentives to seek efficient modes of

care. Depending on the level of the benefit and the response of consumers, providers, and health plans, such an approach might (but would not necessarily) increase the costs borne by beneficiaries. A related approach would be to stimulate private health plans to compete through premiums to a greater degree than they do under current policies. Such an approach might reduce costs to the extent that it gave beneficiaries suitable encouragement to join efficient health plans and provided structured incentives to induce private plans to negotiate rates with providers that grew more slowly than Medicare's current-law payment rates. However, there is little experience on which to base long-range estimates of the cost savings from introducing competitive approaches to Medicare or to assess their effects on beneficiaries.¹

**CONCLUSION: BETTER TO ACT SOONER
RATHER THAN LATER**

Without changes to Medicare—and to other federal programs—the aging of the baby-boom generation will cause a substantial deterioration in the fiscal position of the U.S. government. The sooner we begin to address that problem, the better off we will be. Implementing gradual action today avoids the need for precipitous and disruptive action later—which could take the form of either sudden large constraints on benefits or large increases in taxes that depress marginal work effort and incentives to invest. Phasing in program changes allows for gradual accommodation and time to promote alternatives for the recipient population. And it gives time for the public to modify its expectations and for people to adjust their work and saving behavior.

Most important, taking action now to moderate the long-range spending pressures would lessen the risks of large tax increases or unsustainable borrowing and thus enhance the economic prospects of future generations. Of course, reducing the growth of benefits means lower future payments than those currently scheduled. However, the alternative of doing nothing now could also mean lower future benefits. The potential strain on overall budgetary resources—resources for all other government activities—when the baby boomers start to reach age 65 eight years from now, and Medicare expenditures begin their rapid ascent, may cause lawmakers to curb Medicare spending. Taxes and premiums for Medicare are already lower than the program's expenditures (for HI and SMI combined). That gap—now about \$89 billion—is projected to grow to \$191 billion by 2013.

1. Chapter 4 of CBO's recent publication *Budget Options* (March 2003) discusses in more detail approaches to slow the growth of both Social Security and Medicare.

Looking more broadly, spending for Medicare, Medicaid, and Social Security—the three federal entitlement programs most directly affected by the looming population trends—now absorbs 8 percent of GDP. If CBO’s projections hold, that figure will rise to 14 percent of GDP by 2030. Beyond that year, spending pressures will intensify, with longevity continuing to increase and health costs continuing to grow. Simply weathering the demographic surge of the baby-boom generation will not be enough to restore the federal government’s fiscal posture to its recent norms. By 2075, CBO projects, the cost of the three programs could climb to 21 percent of GDP, the largest portion of which would be attributable to Medicare. To accommodate the increase in spending, either taxes would need to be raised dramatically, spending on other federal programs would have to be curtailed severely, or federal borrowing would soar.

Economic growth is the principal engine to ensure that future retirement needs can be met. However, there is no free lunch. Effective measures will not necessarily be popular measures, and the longer they are deferred, the harder they will be to enact, as those affected grow as a share of the population.

Medicare's Long-Term Financial Viability

Testimony

Presented To

The Joint Economic Committee

UNITED STATES CONGRESS

By

Gail R. Wilensky, Ph.D.

John M. Olin Senior Fellow, Project HOPE

On

April 10, 2003

Mr. Chairman and members of the Joint Economic Committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project HOPE, an international health education foundation and I am also Co-Chair of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans. I have previously served as the Administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) and also chaired the Medicare Payment Advisory Commission. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences directing HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or the Presidential Task Force.

My testimony today discusses Medicare's long-term financial viability, given the impending retirement of 78 million baby-boomers, the effects of adding a Medicare prescription drug benefit, with and without further modernization of the Medicare program and an assessment of how well traditional Medicare has restrained spending compared to both private insurance and to other large public purchasers that use a more market-oriented approach.

Medicare's Long Term Financial Viability

The financial challenges to Medicare are well known and documented annually in the annual report of the Social Security and Medicare Board of Trustees. The 2003 report on the status of the Medicare program was issued last month. In their message to the public, the trustees indicate that although the program is currently running a surplus, its fundamental financial status remains

highly problematic and that deficits to the Social Security and Medicare trust funds are both projected to grow at unsustainable rates.

Medicare is currently spending about \$250 billion for 39 million aged and disabled Americans and spending on Medicare is expected to grow at an annual rate of a little over 7 percent over the next decade. This rate is almost 2 percent faster than the expected annual growth in GDP. After 2012, difference between the Trust Fund's tax income and its expenditures is expected to grow by a rapidly expanding margin.

The long-term outlook for Medicare is primarily driven by demographics. The changing demographics associated with the retirement of 78 million baby-boomers between the years of 2010 and 2030, the expected longevity of the boomers and the smaller cohorts from the baby-bust generation that followed them means that just as the ranks of beneficiaries begins to surge, the ratio of workers to beneficiaries will begin to decline.

The strong economy of the last decade combined with the slow growth in Medicare expenditures from FY 1998-2000 has provided more years of solvency to the Medicare Trust Fund than was initially projected. However, the Medicare or HI Trust Fund is now projected to become insolvent in 2026, four years earlier than was projected last year. Similarly, HI expenditures are now predicted to face a cash flow deficit as early as 2013, rather than in 2016 as was predicted last year. These unfavorable changes relative to last year reflect the combined effects of a drop in payroll tax income and higher than expected hospital expenditures during the year.

As important as issues of Medicare Trust Fund solvency are, however, the frequent focus only on the HI Trust Fund as a reflection of Medicare's fiscal health is unhelpful and misleading. SMI or Part B of Medicare, which is financed 75 percent by general revenues and 25 percent by premiums paid by seniors is a large and growing part of Medicare. Part B currently represents about 42 percent of total Medicare expenditures and is expected to grow to 46 percent of total Medicare expenditures by the end of a decade. With Part B not only growing faster than the Trust Fund expenditures but substantially faster than the economy as a whole, it means that pressure on general revenue from Part B growth will continue in the future even though it will be less observable than HI pressure. It also means that not controlling for Part B expenditures will mean fewer dollars available to support other government programs.

Medicare Prescription Drug Benefit

The most publicized problem of Medicare is its outdated benefit package. Unlike almost any other health plan that would be purchased today, Medicare effectively has no outpatient drug coverage. Medicare also has no protection against very large medical expenses. The reason Medicare's benefits exclude outpatient prescription drug coverage and stop-loss protection is that traditional Medicare is modeled after the Blue Cross/Blue Shield plans of the 1960s and these coverage elements were not included in most insurance plans of the 1960s.

A variety of prescription drug bills have been proposed in the Congress over the past several years. These bills have differed in terms of their coverage and enrollment policies, the amounts and types of cost sharing, the ways in which payments are reimbursed and costs are controlled, and the administration of program. Not surprisingly, the cost of the bills has varied widely as

well—from as little as \$190 billion to as much as \$800- \$900 billion over ten years. The Bush administration recently proposed a drug benefit estimated to cost almost \$400 billion over ten years as part of its larger effort to modernize the Medicare program. This is somewhat more than either the prescription drug bill passed by the House of Representatives last year or the Tri-partisan bill developed by the Senate.

Estimates of the likely cost of a major new benefit should be regarded with some caution. Our history of being able to estimate the costs of major new benefits, none of which were ever as large as what is being contemplated for prescription drugs, is not promising. The cost of the ESRD (end-stage renal disease) program introduced in 1972 was severely under-estimated, and the estimated cost of the prescription drug component of the Medicare catastrophic bill doubled from the time it was passed in June of 1988 to the time it was repealed in August of 1989, and that was without any benefits actually ever being provided.

Some Next Steps

The Congress should be cautious about adding major new commitments to a program like Medicare when it is unclear how the benefits already promised are going to be financed. It is also important for the Congress to recognize that an outdated benefits package is not Medicare's only problem.

There are serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of 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. Seniors and others pay into the program on the basis of income and wages and pay the same premium for Part B services. The large variation in spending for Medicare means there are substantial cross-subsidies from people living in low medical cost areas and areas with conservative practice styles to people living in higher medical cost areas and areas with aggressive practice styles. The Congress and the public are aware of these differences because of the differences in premiums paid to Medicare+Choice plans but seem unaware that the differences in spending in traditional Medicare is now even greater than the variation in Medicare+Choice premiums.

The provider community has also been complaining bitterly about both payment inadequacies and also about the administrative complexities associated with Medicare. Particular concern has been raised about the reduced payments to physicians and whether access to physician care for seniors is in danger of being jeopardized. Payment rates to physicians were reduced by more than 5 percent for FY2002 and would have been reduced by an additional 4.4 percent this month, had it not been for the action recently taken by the Congress. Even with the change, payments are expected to decline again next year if additional changes aren't made to the way physician payments are calculated. Reductions in payments for nursing homes and home health care have also raised issues of future compromises in care although to date there has not been evidence to suggest access to care in either of these areas has become a problem for seniors.

Provider complaints about administrative complexities have been almost as great as their complaints about the levels of payments. Although none of these are new issues, providers have

become increasingly vocal about these concerns. Among the many complaints that have been raised—uncertainty about proper billing and coding, inadequate and incomplete information from contractors and discrepancies in treatment across contractors seems to be at the top of most lists. A report released by the General Accounting Office last year verified the validity of many of the complaints.

Although I believe it is important to pass a reformed Medicare program and that a reformed Medicare should include outpatient prescription drug coverage, I also believe that adding this benefit to the Medicare program that now exists is not the place to start the reform process. There are a variety of problems that need to be addressed in order to modernize Medicare to accommodate the needs of retiring baby-boomers and to make the program financially viable. To introduce a costly new benefit that would substantially increase the spending of a program that is already financially fragile, without addressing the other areas of reform, is unwise.

What Have We Learned About Controlling Spending in Medicare?

In considering future options for Medicare, it is useful to review past attempts to control spending in Medicare and to compare spending under the traditional Medicare program with spending by other payers. Medicare is based on an administered pricing system which means that reimbursements are set by the government rather than by using a market-based system. Sometimes reimbursement in Medicare is set at the unit level, as is the case for physician and lab services and sometimes reimbursement is bundled into a larger package, as it is for hospitals and for home care. Sometimes reimbursement is set so as to reflect historical costs (as was the case

for inpatient hospital spending) and sometimes reimbursement is set to reflect perceptions of what reimbursement “should be”, such as is the case with the resource-based relative value scale used to reimburse physician services.

In the past, most of Medicare’s attempts to control spending have been directed almost exclusively towards providers. Since Medicare provides seniors with a defined benefit that covers all that is “medically necessary” within a given set of services, this means that for the services covered by Medicare, the promise is essentially open-ended. The 20 percent co-payment on Part B services, that otherwise would influence patient use of services, has been effectively nullified by coverage supplementary to Medicare. Between Medicaid, purchased Medigap insurance and retiree insurance provided by former employers, almost all seniors are shielded from Part B co-pays as well as the one-day deductible for inpatient hospital stays. The result is that seniors are not very sensitive to the costs of care covered by Medicare.

How well has the public sector done controlling Medicare spending? In part, it depends on which period is being considered and in part it depends on what comparisons are being used. Using the information presented in MedPAC’s most recent report to Congress provides some interesting insights. In general, growth rates per enrollee over long periods have been roughly comparable, no matter what the comparison. This statement is least true when the comparison is between Medicare and private insurance and more true when the comparison is between Medicare and other large public purchasers such as the Federal Employees Health Benefits (FEHBP) or the California Public Employees’ Retirement System (CalPERS), which seems to me to be the more relevant comparison.

When the comparison is between Medicare and private insurance, Medicare spending grew at a slower rate per enrollee over the long term, even when prescription drug spending is subtracted from private insurance. Of course, coverage in the private sector was also increased substantially during this period, which makes the comparison between spending on Medicare and spending for private insurance even messier than such comparisons are usually. The more relevant comparison is between Medicare and FEHBP or CalPERS since like Medicare, both of these are large public purchasers. Both of these public purchasers use a more market-oriented approach in their contracting with private insurance plans for employee health coverage than does Medicare. Both did about as well as Medicare over the last ten years, FEHBP not quite as well and CalPERS slightly better. Both, of course, provide outpatient prescription drug coverage, which means they have had to deal with rapid spending increases in prescription drug spending over the last several years, unlike Medicare.

Conclusions

Comparing the experience of Medicare with spending by other large public purchasers leads me to several conclusions. First, administered pricing systems can control or moderate spending, particularly following the introduction of major regulatory changes. The larger the change, the bigger the potential for a slowdown in spending, if for no other reason than disruption to usual business practices. The Balanced Budget Act (BBA) was clearly the granddaddy of all changes to Medicare. Prospective payment systems were legislated for outpatient hospital care, nursing home and home care and increased physician spending was restricted to the growth in the overall

economy. It should not be a surprise then that spending slowed dramatically although probably a large part of the unanticipated slowdown in Medicare spending following the passage of BBA reflects a response to aggressive antifraud actions by the government.

Second, certain types of controls can moderate spending indefinitely, if there is the political will to keep them in place. The sustainable growth rate provision in physician reimbursement, which limits growth in physician spending in Medicare to the growth in the economy, will limit spending, if it is followed. It, like the “fail-safe” caps in the 1995 Medicare Preservation Act, operates by brute force. Reimbursements are reduced across all payment categories until the targeted level of spending is achieved. Unlike most other controls in Medicare that directly affect only price, spending caps that include price and quantity controls, will control spending. The results can be harsh and may be regarded as unfair, since the controls affect all providers within the category, without distinguishing between those that are regarded as the “good” providers (on whatever basis) from the rest of the providers. Sustaining this type of control in Medicare, particularly once it is perceived as potentially affecting access, is very difficult in the U.S. as the recent change in physician payment makes clear.

Third, attempts to affect spending that focus only on changing provider behavior produce less leverage than strategies that affect both the behavior of providers and seniors. This is especially a problem if strategies are already in place that shield seniors from the cost of using more or higher priced services. Admittedly, this is how most countries control spending but attempting to moderate Medicare spending only on the supply side is like slamming on the brakes while still depressing the gas pedal.

I believe the Congress should consider using a structure similar to the Federal Employees Health Benefit Plan (FEHBP) for Medicare. This model, where the government's payments on behalf of an individual would not vary with the type of plan that is selected, is consistent with the work of the Bipartisan Commission for the Future of Medicare which was subsequently translated into legislative language in a bill proposed by Senators Breaux and Frist. It is also consistent with the principles articulated by President Bush.

The FEHBP structure is not a panacea for Medicare's problems but I believe it would provide for a more financially stable and viable program. It would provide incentives for seniors to choose efficient health plans and/or providers and better incentives for health care providers to produce high quality, low-cost care. This type of program, particularly if provisions are made to protect the frailest and most vulnerable seniors, would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program for the plan that best suits their needs.

I recognize that the FEHBP is controversial with some in Congress, particularly because of the difficulties that the Medicare+Choice program has been having. It is important to understand, however, that many of the problems of the Medicare+Choice program reflect the decision by the Congress to encourage the expansion of plans in underserved areas by limiting the increase for plans with most of the enrollees to 2 percent per year, even though their costs were increasing at a rate that was several times that amount. In addition, Medicare+Choice plans have faced additional regulatory burdens as well as substantial uncertainties about future changes in

regulation. Combined, these factors have helped transform what had been a vibrant, rapidly growing sector into a stagnant and troubled one.

As we contemplate a Medicare program for the 21st Century, it is important to understand that the people who will be reaching 65 during this decade as well as the baby-boomers, themselves, have had very different experiences compared to today's seniors. Most of them have had health plans involving some form 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 that we need to think about tomorrow's seniors as a different generation, with different experiences, with potentially different health problems and if we start the reform process soon, with different expectations.

THE EXPERIENCE OF OECD COUNTRIES IN COPING WITH RISING HEALTH COSTS

Statement of John P. Martin
Director for Employment, Labour and Social Affairs
Organization for Economic Cooperation and Development
(OECD)

Before the Joint Economic Committee

April 10, 2003

Chairman Bennett, Representative Stark, distinguished committee members, I am John Martin, Director for Employment, Labour and Social Affairs of the Organization for Economic Cooperation and Development. I am pleased to be here with you today to discuss the experience of OECD member countries in coping with rising health costs.

The Medicare program faces economic challenges that are common to many publicly financed health insurance programs across industrialized countries. In my testimony today, I will describe those challenges, the general approaches that have been used to deal with them, and the extent to which those efforts have been successful. My testimony is based on a recent OECD study of the health system reform experience across OECD countries and on a comparative evaluation of the US health system that was published in last year's OECD Economic Survey of the United States. It also draws upon recent OECD work to assess the impact of population aging on future health spending.

1. HEALTH SPENDING TRENDS IN OECD COUNTRIES

- OECD countries face rising health costs, with the United States the biggest spender.*** Health care represents a growing share of OECD countries' economies (Table 1). In 2000, health expenditure represented an average of 8.4 percent of GDP, up from 7.7 percent in 1990 and 7.1 percent in 1980.^{1,2} The United States, spending 13.0 percent of GDP on health in 2000, devotes a greater share of resources to health than any other OECD country.³ The next highest-spending nations, Switzerland and Germany, came in at 10.7 and 10.6 percent, respectively, in that year.
- Health spending growth reflects rising incomes.*** Growth in health spending that outpaces overall economic growth is attributed to several factors. Importantly, per capita health spending is linked to per capita growth in GDP. The effect of income on health spending appears to reflect income's impact on both volume and price of services, in that both the amount of health care consumption and the relatively labor-intensive prices of health services tend to increase with growth in national income. In general, OECD countries with higher per capita GDP tend to spend more per capita on health (Figure 1). However, there is significant variation across countries, which may partly reflect policy decisions regarding appropriate spending levels and the perceived value of additional spending on health relative to other goods and services.
- Advances in medical technology are a major driver.*** Advances in the capability of medicine to treat and prevent health conditions are widely agreed to be the greatest underlying factor driving health cost growth. Recent developments in imaging, biotechnology, and pharmacology suggest that this trend is likely to continue.
- Population aging will also drive health spending higher...*** Population aging is also expected to play an important role in driving future growth in health spending. Health-care costs tend to increase sharply with age beginning at about age 45, tending to fall back at age 80 or 85. Assuming current age-related cost patterns hold over time and that spending is unaffected by other factors, the OECD projects that total health-care spending will increase by an average of nearly 2 percent of GDP over the period 2000 -- 2050 as a direct result of population aging.⁴

¹ *OECD Health Data*, a compilation of internationally comparable statistics on health spending, health, and health systems, is issued annually as a CD ROM. Analyses based on the data, including tables, charts, and supporting explanations, are published by the OECD in *Health at a Glance*.

² Reflecting the availability of comparable data across years, these averages refer to 19 of the 30 OECD countries.

³ 2000 is the latest year for which internationally comparable data on health spending are currently available.

⁴ These projections are based on data from 18 OECD countries, not including the United States.

Public Sector Spending on Health

... putting further pressure on public budgets.

In most OECD countries, concern about health cost growth reflects the pressure such growth places on public budgets. Given the predominance of publicly financed health insurance coverage or direct public financing of care in most OECD countries, the public sector accounts for the greatest part of health spending in all countries except Korea, Mexico, and the United States (Figure 2). Nevertheless, the United States' public sector spends as much per capita on health as the average OECD country spends in total (public and private), even though only about one-quarter of Americans are publicly insured.⁵

2. APPROACHES TO HEALTH COST-CONTAINMENT IN OECD COUNTRIES

Several approaches have been used to rein in spending.

Faced with a rising trend in their health spending, most OECD countries have sought to rein in this growth over the past two decades. Typically, the approaches used to slow the growth in public-sector spending have relied on three types of policies: (1) regulation of prices, input resources, and (to a lesser extent) health care service volumes; (2) caps on health spending, either overall or by sector; and (3) shifts of costs onto the private sector.

Administered pricing and controls on health care production inputs

Price and wage controls are common.

Most countries regulate health-sector prices and/or service volumes in some fashion. Wage controls are prevalent in systems where most of the health care workers are public-sector employees, as they are in the Nordic countries, Greece, Italy, and Portugal. In other systems, prices for medical services, supplies, and institutional care are usually set administratively, as in the US Medicare program, or governments provide oversight on prices agreed between health-care purchasers and providers. Most countries take steps to influence service volumes, ranging from controls over medical school admissions and other workforce policies to more direct efforts to control hospital sector capacity.

Such tools can be effective, although they have limits.

While such tools can curb spending growth, the impact of price controls on health expenditure can be limited by provider responses, as experience has shown that health care providers respond to the economic incentives established in payment systems. For example, to compensate for price limits, practitioners may increase the volume of services provided or change the mix of services to include more of those paid at a higher rate. Sometimes services are shifted into sectors or systems where there are no price controls, something that has occurred in some countries where public and private programs operate side-by-side, as in Greece and Ireland.⁶ And patients may be up-coded to higher level payment classifications, where such differentiation is built into payment systems. Thus, the success of price controls as a cost-containment

⁵ Those covered by public insurance in the United States include elderly and disabled persons, who are relatively high users of health care.

⁶ In Eastern Europe, where over-supply of health care resources is a legacy from the communist era, prices and wages in the health sector remain low and under-the-table gratuity payments to providers are common.

tool depends on the extent to which payment systems can be gamed, the administrative costs associated with their use, and whether prices are set at levels that correspond to the costs of health care delivery by an efficient provider. A more important limitation over the longer term is that long periods of wage or price restraint can seriously limit the ability of the health-care sector to attract qualified personnel and maintain health care capacity

Budget caps

Budget caps are also widely used.

Budgetary caps or controls have been widely used as an instrument for containing expenditure. Initially, these were directed at the hospital sector, the most costly element of the system. They were subsequently extended to other providers and suppliers so as to improve ability to control overall expenditure, particularly given the potential for substitution across sectors. Spending controls now often include global budgets spanning all components of public spending on health and supplementary spending caps on ambulatory care and pharmaceuticals.

They also can be effective, although they risk undesired side-effects.

In general, use of budgetary caps to control spending appears to have been most successful in countries where health care delivery is a public-sector responsibility -- as in Denmark, Ireland, and New Zealand -- and in single-payer countries, like Canada. Where budget limits are firm and enforceable, they can serve as a powerful tool to limit spending. However, top-down spending constraints in the form of budget caps can also have undesirable incentive effects in that they can provide little incentive for providers to make efficiency gains or increase productivity. For example, fixed budget ceilings encourage providers and suppliers to spend up to the ceiling. Setting budgets based on historical costs may favor inefficient providers and penalize efficient ones. As a consequence, OECD countries have been moving increasingly to combine budget caps with measures that take account of levels of output and relative efficiency across hospitals.

Cost shifting to patients

Although the degree varies across countries, an increase in cost-sharing for medical care has been a common feature over the 1980s and, particularly, the 1990s. Greater cost-sharing has mainly affected pharmaceuticals, while patient payments for inpatient and doctor visits have been less widespread.⁷ The number of drugs not reimbursed has increased, mainly for “comfort” drugs or those without proven therapeutic value. The degree of cost-sharing has been increased for many others. In a number of cases, flat-rate payments per prescription have been established. Reference price systems have also been introduced in a number of countries. These arrangements increase cost-sharing for individuals using branded or higher cost products while assuring access to less costly generic drugs.

... and the public share of total spending fell slightly.

Cost-sharing measures appear to have had an impact on the share of public spending in total spending (Table 2). Following large increases relating to the expansion of public health insurance programs in the 1970s, the increase in the public share of total health spending slowed markedly in the 1980s. Between 1990 and 2000, the average share of total health spending represented by the public sector declined slightly from 72.5 percent to 71.5 percent.⁸

3. THE EFFECTS OF COST-CONTROL INITIATIVES

Spending growth has slowed.

Cost-containment efforts such as those described above coincided with a decline in the rate of spending growth across many OECD countries. On average, there has been a fall in the rate of growth in health expenditures across OECD countries over the past three decades: the average annual growth rate dropped from 6 percent in the 1970s to 3.2 percent in the 1980s and to 3 percent in the 1990s. Nonetheless, while spending growth has slowed considerably over the past two decades, health spending continues to grow at rates exceeding overall economic growth in many OECD countries.⁹

Judging the appropriateness of spending levels is challenging.

Such growth is not necessarily problematic from a policy perspective. Indeed, an emerging dilemma facing governments after this period of restraint is judging the “appropriate” level of health spending. On the one hand, social welfare may well be improved by increased government spending, particularly if demand for health-care services tends to rise more rapidly than income and if the cost of technological change is more than compensated by improvements in the quality of care and resulting outcomes. On the other hand, the economics

⁷ Such policies presumably reflect the higher price elasticity for pharmaceutical drugs than for ambulatory and, particularly, for hospital care.

⁸ The average dropped over the decade in 18 of 27 countries for which data are available and remained constant in one country. Those countries where the public share increased tended to be those, like the United States, Mexico, Portugal, and Turkey, in which the public share was lower than the OECD average in 1990. Hence, the tendency has been toward a reduction in the extent of variation across countries.

⁹ In many countries, including the United States, growth rates picked up at the end of the 1990s and this trend appears to have continued in the early part of this decade. In a few cases, this growth coincided with deliberate policies to increase spending.

of the health sector, typically characterized by market failures and heavy public intervention, suggest a risk of excess or misallocated spending, with equivalent health outcomes possibly attainable at lower cost.

4. NEW DIRECTIONS FOR REFORM: THE MOVE TO COST-EFFICIENCY ORIENTED REFORMS

Large differences in inputs, practice patterns and outcomes exist across OECD countries.

Although the efficiency of health-care systems (*i.e.*, achievement of maximum outputs for a given level of spending or achievement of comparable outputs at lower cost) is hard to measure, evidence suggests that there are large differences across OECD countries -- and even within countries -- in what is produced, in the way that it is produced, and in the resulting impacts on health outcomes. The level of capital and human resources employed in the health sector shows wide variation across countries.¹⁰ In addition, there are as many different combinations of spending on ambulatory and inpatient care as there are countries and there are also very different levels of specialist care and use of pharmaceuticals. For any given health condition, wide differences also exist in the treatment and in the intensity of care (practice patterns), both within and between countries.¹¹

Hence, improved efficiency is a major focus of current health reforms.

Improvements in the efficiency of health systems have been an important focus of reforms in OECD countries, particularly over the past decade or so and these efforts are continuing today. Improved efficiency is desired both to offset the budgetary impact of increased demand for health care and to improve the return on health spending. Reforms to-date have focused on modifying payment arrangements so as to better align the incentives of health-care providers -- and, in some cases, patients -- with efficient production and use of health services. There has also been increased interest -- although less experimentation -- in introducing to the health sector more of the elements found in normal economic markets, such as competition among health care providers or insurance funds, and greater use of price signals.

Better purchasing arrangements and experiments to enhance competition have been tried.

In countries with health systems in which the financing and delivery of health care is an integrated, public-sector function, efficiency-related reforms have included:

- making a greater separation between the health-care purchasing and providing functions with the introduction of clearer contractual relations and better indicators of what and how much is to be supplied;
- better aligning payment incentives with objectives for provider performance;

¹⁰ For instance, the number of practicing physicians per 1 000 population in 2000 averaged 3.0 across the OECD, with a standard deviation of 1.0. The United States, at 2.8, stood at slightly below the OECD average. However, this rate does not take into account differences in productivity and how resources are deployed.

¹¹ Recent OECD work evaluated differences across countries in practice patterns, resources, and outcomes for ischaemic heart disease, breast cancer, and stroke. Proceedings from the project's concluding workshop will be published by the OECD later this month as *A Disease-Based Comparison of Health Systems: What is Best and at What Cost?*

- decentralizing decision-making in efforts to better match local supply and demand; and
- introducing greater competition among providers.

Policies to create a purchaser – provider split have been sustained, but efforts to foster competition among providers have been less successful.

While the potential impact of such policies on efficiency has most often been dampened by tight spending limits and supply constraints, policies aimed at creating a purchaser-provider split and decentralization reforms have usually been sustained. However, experiments designed to foster competition among providers, which have also been undertaken in multiple-payer systems, have been less successful and reforms have been reversed in those countries (e.g., New Zealand, Sweden, and the United Kingdom) where they were introduced. Failures partly reflected tight supply conditions and monopoly positions of providers in local health care markets, strong information asymmetries, and lack of sufficiently skilled purchasers. Positive results from competition probably require establishing market conditions conducive to competition, better purchasing capacity, and the information base needed to appropriately set and monitor contracts.

New provider payment systems can improve efficiency.

One seemingly successful area of efficiency-oriented reforms has been in the area of provider payments. New payment systems can enhance productivity if introduced carefully. For example, output-related prospective payment systems --- notably hospital payment systems that assign a payment rate based primarily on diagnosis, rather than length of stay --- encourage providers to minimize costs. They can avoid adverse effects on patient care if associated prices are set correctly and there is appropriate control of quality and of strategic provider behavior.

But efforts to increase competition among insurers have yielded mixed results.

Experience with efforts to increase competition among insurers, the most salient feature of reforms in multiple-payer systems, is mixed. In the few countries where such reforms have been introduced -- Belgium, the Czech Republic, the Netherlands, and Germany -- there is some evidence that increased insurance market competition may have had some positive effects by narrowing the premia across insurers, encouraging better service and instituting incentives for administrative cost reduction.¹² However, as in the United States, market segmentation by risk can be problematic where insurers can benefit from enrolling better risks because of inadequate payment adjustment methods. In addition, price negotiation and selective contracting among providers by competing insurers appears to have been successful in slowing cost growth under some circumstances.

While managed care has had some success in the U.S, other countries are wary of it.

Experience from the United States suggests that managed-care arrangements, under which patients accept some limitations on choice of providers and services, may be particularly adept at increasing efficiency by containing costs without harming health outcomes. However, managed care continues to be viewed warily by policy makers in many OECD countries and many countries therefore limit insurers' ability to contract selectively. In line with the recent trend in the United States, the overall OECD trend has been to increase, rather than decrease, patient choice of provider and treatment. At the same time, a number of countries are introducing patient-oriented economic incentives

¹² Switzerland also has private health insurance markets and allows consumer switching. However, in Switzerland, there appears to be considerable consumer loyalty to individual funds and, despite very large differences in premiums, consumer flows from high to low-cost funds have been limited.

-- such as reference pricing systems for prescription drugs -- that give patients incentives to make economical choices among alternative services.

5. LOOKING AHEAD

There are no universal solutions. Experience has shown that there is no one-size fits all solution to problems with escalating health-care costs and health-system inefficiencies. Trade-offs across policy goals -- between containing costs and improving health system responsiveness, for example -- may be inherent in some policy decisions. In many cases, decisions about which path to pursue in undertaking reforms depend largely on decisions about the relative weights to apply to policy goals such as promoting adequate and equitable access to services, ensuring delivery of safe and effective care, and containing the rate of growth in spending.

Further health spending growth is expected. As OECD countries look to the future, they increasingly recognize that further growth in health costs is likely, reflecting rising incomes and demand for care, aging populations, and continued improvements in the capacity of medicine to allay disability and disease. Policy makers will therefore need to ensure that health financing systems are prepared to meet the growing burden with the minimum impact on economic growth, taking into account horizontal and vertical equity considerations.

Investments geared toward efficiency gains are under way. OECD countries are increasingly recognizing that efforts to improve the value of health spending may require additional investments in the short term. We have seen increased attention to building better health information systems, developing improved measures of health system performance, improving payment systems so as to better align economic incentives with desired outputs, and investigating the factors explaining differences in health system performance.

Mr. Chairman, this concludes my statement. I would be pleased to answer any questions you or other committee members may have at this time.

Figure 1. Per capita GDP and per capita health expenditure, 2000

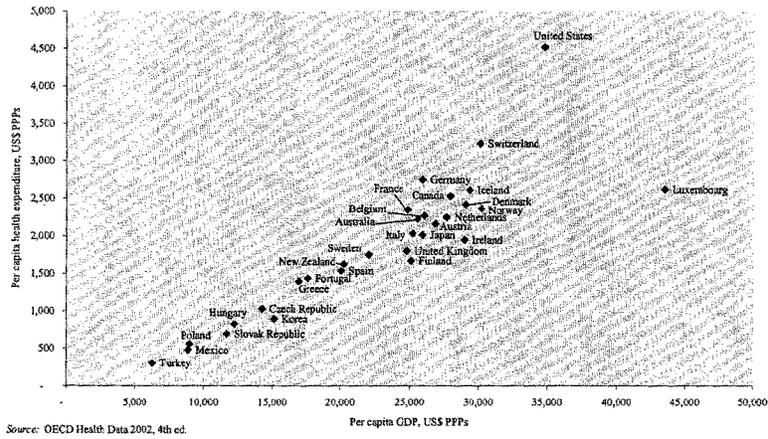
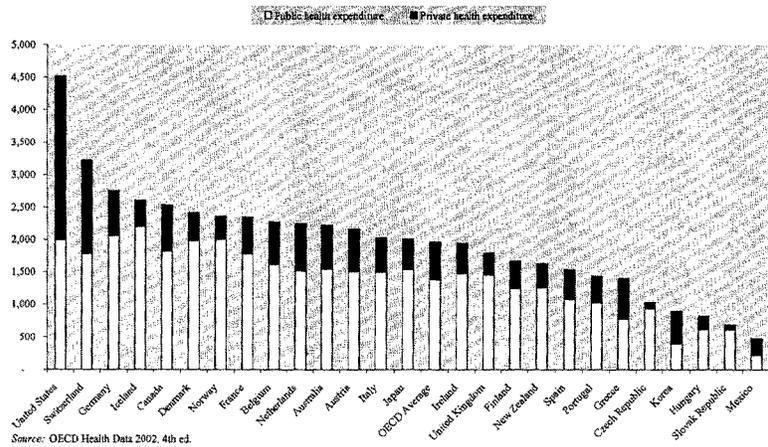


Figure 2. Per capita expenditure on health, 2000, in US\$ PPPs



Note: Luxembourg, Poland, Sweden and Turkey are not included in the average.

Table 1: Total health expenditure as a percentage of GDP, 1970 - 2000

					Change		
	1970 ^{a)}	1980	1990 ^{b)}	2000 ^{c)}	1970-1980	1980-1990	1990-2000 ^{d)}
Australia	5.6	7.0	7.8	8.3	1.4	0.8	0.5
Austria	5.3	7.6	7.1	8.0	2.3	-0.5	0.9
Belgium	4.0	6.4	7.4	8.7	2.4	1.0	1.3
Canada	7.0	7.1	9.0	9.1	0.1	1.9	0.1
Czech Republic	..	..	5.0	7.2	..	..	2.2
Denmark	8.0	9.1	8.5	8.3	1.1	-0.6	-0.2
Finland	5.6	6.4	7.9	6.6	0.8	1.5	-1.3
France	..	..	8.6	9.5	..	..	0.9
Germany	6.3	8.8	8.7	10.6	2.5	-0.1	0.7
Greece	6.1	6.6	7.5	8.3	0.5	0.9	0.8
Hungary	..	..	7.1	6.8	..	..	-0.3
Iceland	4.9	6.1	7.9	8.9	1.2	1.8	1.0
Ireland	5.1	8.4	6.6	6.7	3.3	-1.8	0.1
Italy	..	..	8.0	8.1	..	..	0.1
Japan	4.5	6.4	5.9	7.8	1.9	-0.5	1.9
Korea	..	..	4.8	5.9	..	..	1.1
Luxembourg	3.6	5.9	6.1	6.0	2.3	0.2	-0.1
Mexico	..	..	4.4	5.4	..	..	1.0
Netherlands	6.9	7.5	8.0	8.1	0.6	0.5	0.1
New Zealand	5.1	5.9	6.9	8.0	0.8	1.0	1.1
Norway	4.4	7.0	7.8	7.8	2.6	0.8	0.0
Poland	..	..	5.3	6.2	..	..	0.9
Portugal	2.6	5.6	6.2	8.2	3.0	0.6	2.0
Slovak Republic	..	..	..	5.9	..	..	..
Spain	3.6	5.4	6.6	7.7	1.8	1.2	1.1
Sweden	6.9	9.1	8.5	7.9	2.2	-0.6	-0.6
Switzerland	5.6	7.6	8.6	10.7	2.0	1.0	2.1
Turkey	2.4	3.3	3.6	4.8	0.9	0.3	1.2
United Kingdom	4.5	5.6	6.0	7.3	1.1	0.4	1.3
United States	6.9	8.7	11.9	13.0	1.8	3.2	1.1
Total OECD ^{e)}			7.2	7.9			
OECD 19 Country Average ^{f)}	5.4	7.1	7.7	8.4	1.7	0.6	0.6

.. Data not available.

a) Data refer to 1971 for Austria and Denmark and to 1972 for the Netherlands.

b) Data refer to 1991 for Hungary.

c) Data refer to 1999 for Luxembourg and Poland and to 1998 for Sweden and Turkey.

d) German figures are for 1992-2000.

e) Unweighted average for 29 countries. Figures exclude the Slovak Republic.

f) Unweighted average. Figures exclude Belgium, Czech Republic, France, Greece, Hungary, Italy, Korea, Mexico, Poland, the Slovak Republic and Turkey.

Source: OECD Health Data 2002, 4th ed.

Table 2. Public share of total health expenditure: 1970-2000

	Percent of total spending				Change in percentage points		
	1970 ^{a)}	1980	1990 ^{b)}	2000 ^{c)}	1970 ^{a)} -1980	1980-1990 ^{b)}	1990 ^{b)} -2000 ^{c)}
Australia	62.7	63.0	67.1	72.4	0.3	4.1	5.3
Austria	63.0	68.8	73.5	69.7	5.9	4.7	-3.8
Belgium	..	..	..	71.2	..	..	..
Canada	69.9	75.6	74.6	72.0	5.7	-1.0	-2.5
Czech Republic	96.6	96.8	96.2	91.4	0.2	-0.7	-4.8
Denmark	83.7	87.8	82.7	82.1	4.1	-5.0	-0.7
Finland	73.8	79.0	80.9	75.1	5.2	1.9	-5.9
France	..	..	76.6	76.0	..	..	-0.6
Germany	72.8	78.7	76.2	75.1	5.9	-2.5	-1.1
Greece	43.3	55.7	62.7	55.5	12.4	7.0	-7.2
Hungary	..	..	89.1	75.7	..	..	-13.5
Iceland	82.6	88.2	86.6	84.4	5.6	-1.6	-2.2
Ireland	81.6	81.5	73.1	75.8	-0.1	-8.4	2.7
Italy	..	..	79.3	73.7	..	..	-5.6
Japan	69.8	71.3	77.6	76.7	1.5	6.3	-0.9
Korea	..	..	36.6	44.4	..	..	7.8
Luxembourg	89.3	92.9	93.1	92.9	3.6	0.2	-0.2
Mexico	..	..	40.8	46.4	..	..	5.6
Netherlands	60.7	69.4	67.1	67.5	8.6	-2.3	0.5
New Zealand	80.3	88.0	82.4	78.0	7.7	-5.6	-4.4
Norway	91.6	85.1	82.8	82.8	-6.5	-2.3	0.0
Poland	..	..	91.7	71.1	..	..	-20.5
Portugal	57.1	64.5	65.5	71.2	7.3	1.0	5.6
Slovak Republic	..	..	..	89.6	..	..	..
Spain	65.4	79.9	78.7	69.9	14.5	-1.2	-8.8
Sweden	86.0	92.5	89.9	83.8	6.5	-2.7	-6.1
Switzerland	..	..	..	55.6	..	..	..
Turkey	37.3	27.3	61.0	71.9	-10.0	33.7	11.0
United Kingdom	87.0	89.4	83.6	81.0	2.4	-5.8	-2.5
United States	36.4	41.5	39.6	44.3	5.1	-1.9	4.7
OECD comparable average ^{d)}	67.8	71.7	72.5	71.5	3.9	0.8	-1.0
Standard deviation of comparable average	17.3	17.5	12.7	10.9	5.5	8.5	4.8

.. Data not available.

a) Data refer to 1971 for Australia and Denmark; 1972 for Netherlands.

b) Data refer to 1991 for Hungary.

c) Data refer to 1998 for Sweden and Turkey; 1999 for Luxembourg and Poland.

d) Unweighted average of 21 countries. Figures exclude Belgium, France, Hungary, Italy, Korea, Mexico, Poland, Slovak Republic and Switzerland.

Source: OECD HEALTH DATA 2002 4th ed.

Assessing the Viability of Medicare

Marilyn Moon

Senior Fellow

The Urban Institute

Testimony for

The Joint Economic Committee Hearing

April 10, 2003

The material presented in this testimony represents the opinions of the author and not of the Urban Institute, its officers or funders. Much of the research reported here was funded by the Commonwealth Fund and the Henry J. Kaiser Family Foundation.

Mr. Chairman and Members of the Committee: Thank you for extending to me the opportunity to testify at this hearing.

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. In order to meet this challenge, the nation must plan how to share that burden and adapt Medicare to meet new demands.

Nonetheless, Medicare is a viable program. In terms of meeting the needs of those it is intended to serve—older and disabled individuals—and in terms of future affordability, the program can continue to succeed. It is neither unsustainable nor fatally flawed.

To support these claims, I make five points in my testimony. First, the drivers of healthcare costs are not unique to Medicare, and it is important to recognize that Medicare needs to grow in concert with changes in the healthcare system as a whole. Second, even with no changes in the basic program, the burdens from Medicare are not excessive in the context of reasonable expectations about economic growth in the future. To demonstrate this, I present an alternative measure of affordability that I have written about in more detail elsewhere. Third, passing greater costs onto older and disabled Americans must be done with caution, recognizing

that their burdens will also rise even with no change in policy. And no matter what happens to public policy, this population will still need to get care somewhere. Fourth, part of the argument that Medicare is unsustainable or not viable is often linked to the claim that, as a public program, Medicare is less efficient than if it were run through the private sector. Again, this is not supported by the facts. Finally, I briefly describe a number of changes that could improve Medicare.

REASONS FOR RISING COSTS

Projections from the 2003 Medicare Trustees Report indicate that Medicare's share of the Gross Domestic Product (GDP) will reach 4.75 percent in 2030, up from 2.56 percent in 2002. Although this is a substantial increase, it is actually smaller than what was being projected just a few years ago. In 1996, for example, the projection for 2030 was 7.39 percent of GDP—or 56 percent higher than the projection made this year. This slowdown in growth does not eliminate the need to act, but it does allow time for study and deliberation before putting substantial changes into place.

Projected increases in Medicare's spending arise because of growing numbers of people eligible for the program and the high costs of health care. The beneficiary population is rising because of increased life expectancy (in part reflecting the success of the Medicare program) and that growth will be accelerated in the future by the retirement of the baby boom. The number of younger disabled beneficiaries is also expected to remain high. This creates challenges for Medicare and represents a major component of spending projection increases. By 2030, for

example, the number of beneficiaries will reach 79 million—nearly double today’s number.

Technological advances that raise the costs of care are the primary reason for higher per capita spending over time, and this phenomenon occurs systemwide, not just in Medicare. The problems driving Medicare costs upward are not unique to the public sector. They are found throughout our nation’s healthcare system, and the crisis of rising healthcare costs affects all payers: individuals, businesses, and governments. And just as Medicare is influenced by the overall healthcare system, the opposite is true as well. Medicare has been a leader in experimenting with options for curbing the costs of care, both in terms of increasing prices and use of services. Further, while costs continue to rise, efforts through time to hold down these costs have led to a better outlook than was the case in the mid-1990s. Similar re-evaluation of the program to make changes where needed will be an important part of Medicare’s future.

MEASURING MEDICARE’S FINANCIAL BURDENS

Medicare is currently financed in a variety of ways. Part A relies mainly on payroll taxes with a modest contribution from part of the taxes imposed on Social Security benefits. Part B, on the other hand, is financed by enrollee premiums set at 25 percent of the costs of Part B benefits for elderly beneficiaries and by general revenue contributions sufficient to cover the remaining costs.

Medicare’s financial health can be viewed from several perspectives. The appropriate question over time is whether, *as a society*, we can afford to support Medicare. But the measures often used actually focus on a narrower issue of solvency, particularly that of the Part A Trust

Fund. That measure does point to the need for some type of policy change in the future, but that could simply mean increasing the revenues going into the trust funds, for example.

Solvency Measures

Solvency, as measured by the date of exhaustion of the Part A Trust Fund, is one of the most commonly reported statistics about Medicare.¹ This is just one of many measures reported in the Medicare Board of Trustees annual reports on Medicare's financial outlook. Critics of Medicare often emphasize the solvency of the Part A Trust Fund as an indicator of *affordability* as well as solvency. This implicitly treats the Part A Trust Fund as establishing a limit on what can be spent on Part A.

The Part A Trust Fund was designed to assure that the specified payroll tax contribution would be used specifically for Part A spending. As dedicated revenues, payroll and other revenue sources that exceed the amount necessary to cover Part A benefits go into the Trust Fund and collect interest. When the trust fund forecasts indicate a declining balance, this serves as an early warning of the need for an adjustment either in revenue contributions or spending on the program. Over the next ten years, Medicare revenues will exceed spending by over \$500 billion.

Projections of the Medicare Part A trust fund in the most recent Trustees' Report indicate that it will maintain a positive balance through 2026. Considered in historical context, the date of projected insolvency historically is far into the future as compared to what it has been in earlier years (Figure 1). The trust fund is expected to grow until 2014, after which the trust

¹Although there is also a Part B Trust Fund, it serves a much different purpose and is intentionally kept at a small positive level.

fund's balances will begin to decline. At that point, payroll tax and other receipts are insufficient to cover all expenditures. After 2014, Part A of Medicare must supplement tax revenues with funds accumulated in the Part A Trust Fund.

Another solvency measure that was contained in the Administration's budget documents for this year indicated that there was a \$13.3 trillion unfounded liability facing Medicare over the next 75 years. But this is based on very misleading figures. The text implies that payroll taxes are the only revenue source from which Medicare is allowed to draw to cover its costs. While Part A is largely funded by payroll taxes, Part B *by law* has always relied on general revenues. Including its costs in an analysis of the adequacy of the current payroll tax has as much validity as treating any other expenditure covered by general revenues (such as defense) as having large unfounded liabilities as well. If done correctly, the "unfounded promises" under Medicare would be much lower, more in the range of \$5 trillion.

That is not to say that this is not a large amount, but rather that the size is more manageable than the \$13.3 trillion implies. It is important to note, for example, that in the next ten years, Part A revenues will exceed Part A spending by over \$500 billion.

Affordability Measures

Assessing affordability using the solvency of the Part A Trust Fund as the measure is analogous to individuals arguing that they cannot pay all their bills because the balance in one of their checking accounts is too low. Affordability is a broader issue that turns on whether we as a society can support Medicare into the future. The need for healthcare for this segment of the

population will not go away simply because we decide to cut back on government's contribution. But the ability of Medicare beneficiaries to absorb higher healthcare costs if no new revenues are forthcoming would be in serious doubt.

The Medicare Trustees Annual Report offers two broader measures of affordability described below, although each are limited in scope. Thus, an alternative measure presented here proposes a more comprehensive way to examine affordability.

The Worker-to-Beneficiary Ratio. The ratio of workers contributing to Medicare at any point in time compared to the number of beneficiaries shows that the number of younger persons relative to older ones will decline in the future given the aging of society. This declining ratio of workers to retirees indicates that each worker will have to bear a larger share of the cost of providing payroll tax-financed Medicare benefits.

Between 2002 and 2030 (about the time when most Baby Boomers will have become eligible for Medicare), the ratio of workers to beneficiaries will fall from 3.9 to 2.4. Indeed, this is one of the statistics commonly cited by those who claim the program is "unsustainable." This measure does signal the need for more revenues per worker—a legitimate issue for debate. However, it fails to assess the level of burden relative to ability to pay from each future worker, ignoring any improvement in the economic circumstances of workers over time due to per capita economic growth.

Medicare Spending as a Share of GDP. A second measure is the sum of Part A and B

spending as a share of GDP. In 2002, Medicare's total share was 2.56 percent and is projected to rise to 4.75 percent in 2030. This represents a doubling of the GDP share. Such an increase reflects the fact that health care costs per capita are expected to continue rising, and the number of people covered will double over that time period. But again, this measure is not as helpful in the debate on Medicare's future because it does not consider how well off we will be as a society as the level of GDP grows. Some goods and services, like health care, may appropriately grow as a share of GDP in response to higher living standards and preferences of the population. What is needed is more information to be able to understand the consequences of devoting a higher share of society's resources to Medicare.

A More Comprehensive Measure of Affordability. Another way to look at affordability is to focus not just on the number of workers that contribute to payroll and income taxes or on aggregate GDP, but instead on how the Medicare per capita burden will affect workers over time. While the share of the pie (GDP) going to Medicare is likely to rise, if the pie (on a per capita basis) is also much larger, then an increasing share is less of a burden. If the future leads to increased national well-being, additional resource sharing would be affordable. Thus, another way to examine affordability is to focus on whether taxpayers of the future will be better off even after they pay higher amounts for Medicare.

This approach measure begins with computing per worker GDP over time, resulting in a measure of the nation's output of goods and services divided across the working population. This provides the base for assessing Medicare's burden on workers, who pay for the bulk of

support for the program. Per worker GDP—even after adjusting for inflation—rises substantially, from \$69,000 per worker in 2002 to just under \$107,000 in 2035 (in 2003 dollars).² This is an increase of 54.9 percent in per worker GDP, a substantial increase in financial well-being.

What about Medicare's costs over this period? The burdens from Medicare spending on each worker are projected to rise at a faster rate than per capita GDP because both numbers of beneficiaries and their inflation-adjusted spending will rise over time. But because per worker GDP is a much larger dollar amount than the dollars of Medicare burdens, the reduction in well-being that this entails for workers is modest.

To calculate this per worker burden from Medicare, several adjustments are necessary. First, each worker will bear an increasing share of Medicare over time because of the change in the ratio of workers to retirees. Further, per capita Medicare costs are expected to rise by 90 percent in real terms by 2035, also increasing the real dollar burden on workers. But not all of Medicare's costs are borne by workers. Thus, costs are adjusted downward by the contributions that will be made by beneficiaries themselves. The Part B premium accounts for about 10 percent of Medicare's costs. In addition, beneficiaries make further contributions because some of the taxation of Social Security benefits goes into Part A and older and disabled persons also pay income taxes that help support Part B. Thus, those costs need to be netted out.

The resulting real per worker burden estimates range from \$1,556 in 2002 to \$4,993 in

²The figure used here is based on the intermediate projections from the 2002 Trustees Report, which assumes a 1.1 percent real growth in per worker wages each year. Over the past 50 years, productivity has been higher than this amount, averaging over 1.5 percent per year.

2035 (in 2002 dollars). In Figure 2, the bar graph indicates per worker GDP in inflation-adjusted dollars, and the line graph indicates how much would be left after accounting for the Medicare burden.

From 2002 to 2035, the increase in net (after subtracting Medicare) per worker resources would be 51.0 percent as compared to the 54.9 percent increase in per worker GDP. That is, workers would still be substantially better off than today, even after paying the full projected costs of Medicare. The pie will indeed have gotten larger, making it possible to absorb Medicare's higher costs. Essentially our estimates indicate that Medicare's greater burdens would "consume" about 7 percent of increased well-being for workers over that period. There will, of course, be other demands on these resources as well, but this approach puts demands from Medicare into a broader perspective. This measure for examining affordability takes into account Parts A and B of Medicare, and it puts the issue of the burdens of the program into a per worker context.

This more comprehensive measure of net per worker output also suggests that, as a society, we will be able to afford Medicare without an inordinate burden on workers or taxpayers once even modest estimates of productivity growth over time are taken into account. A greater challenge will be for society to decide whether it is *willing* to share these costs.

HOW MUCH SHOULD BENEFICIARIES BE ASKED TO PAY?

The burdens of higher health care costs in the future will likely need to be shared between beneficiaries and younger taxpayers in some manner deemed reasonable. The numbers above

already give a sense that future workers will be in a reasonable position to pay more. What about beneficiaries?

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. In 2003, beneficiaries will spend about 23 percent of their incomes on average for acute health care. In a study I did with Stephanie Maxwell and Misha Segal, we projected per capita out-of-pocket spending based on projected Medicare growth into the future and found that the average beneficiary in 2025 would likely have to pay nearly 30 percent of her income on health care because the costs of care grow faster than incomes over time. Figure 3 also indicates how these burdens would grow for other groups of the Medicare population.

Thus, a difficult question to answer will be how much more can be shifted onto beneficiaries over time? If incomes rise faster than anticipated and health care spending moderates, there will certainly be room for greater contributions. But a full shifting of additional costs does not seem to be a viable option. Moreover, it will be very important to take special care with the most vulnerable beneficiaries.

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. Participation in the Medicare Savings programs is low, likely in part because these programs are run by Medicaid and are thus tainted by association with a “welfare” program. Further, states, which pay part of the costs, tend to be unenthusiastic about these extra program and likely discourage participation.

WOULD RELYING ON THE PRIVATE SECTOR MAKE MEDICARE A MORE VIABLE PROGRAM?

Much of the debate over how to reform the Medicare program has focused on broad restructuring proposals, moving the management and oversight increasingly under the control of private insurance. What are the tradeoffs from increasingly relying on private plans to serve Medicare beneficiaries? Most important, there is little evidence to suggest even modest savings to Medicare from increased competition and the flexibility that the private sector enjoys. Further, 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.

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 more efficient than Medicare, and second, that competition among plans will generate more price sensitivity on the part of beneficiaries and plans alike. Although seemingly credible, these claims do not hold up under close examination.

Looking back over the period from 1970 to 2000, a recent study I completed with Cristina Boccuti found that Medicare's cost-containment performance has been better than that of private insurance even after controlling for coverage of comparable services. Starting in the 1970s, Medicare and private insurance plans initially grew very much in tandem, showing few discernible differences (See Figure 4). By the 1980s, per capita spending had more than doubled in both sectors. But Medicare became more cost-conscious 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 mid 1990s when private insurers began to take seriously the rising costs of health insurance. At that time, growth in the cost of 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 2000, 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. When comparison is made on rates of growth for comparable benefits, Medicare's cumulative rate is 19 percent below that of private insurance.

Technological change and improvement represents 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 private insurance as well as Medicare in the future, and it is not clear whether the public or private sector is better equipped to do this.

Reform options such as the premium support approach also 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. Older persons may be less willing to change doctors and learn new insurance rules in order to save a few dollars each month. 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. (If new enrollees go into such plans each year, some savings will be achieved, but these are the least costly beneficiaries, and may lead to further problems as discussed below.) Will they seek to improve service or instead focus on marketing and other techniques to attract a desirable, healthy patient base? It simply isn't 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. Thus, the most vulnerable may stay in plans that become inordinately expensive. 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 such as making sure that the sickest beneficiaries get high quality care; 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.

Ultimately, projected cost savings from a private insurance initiative arise from passing costs off onto beneficiaries through higher premiums or increased cost sharing requirements. If that indeed is the case, then this approach merely represents an elaborate way to avoid an honest debate about how to share future burdens.

CHANGES TO IMPROVE MEDICARE

Making changes to Medicare that can improve its viability both in terms of its costs and in how well it serves older and disabled beneficiaries should certainly be pursued. Further, it makes little sense to look for a solution that takes policy makers permanently out of Medicare's future. The flux and complexity of our healthcare system will necessitate continuing attention to this program. At present a number of areas in Medicare need attention.

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.

Critics of Medicare rightly point out that the inadequacy of its benefit package 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. 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. That logic actually should run in the other direction. It is not reasonable to expect any number of other changes to work without first offering a more comprehensive benefit package for Medicare. In that way, payments made to private plans can improve, allowing them to better coordinate care. And the fee for service system will also be able to change in ways that might encourage better

care delivery. For example, it is not reasonable to ask patients to participate in a program to reduce hypertension (which can save costs over the long run) without covering the prescription drugs that are likely to be an essential part of that effort. In addition, a better benefit package will also allow at least some beneficiaries to forego the purchase of inefficient private supplemental insurance. That itself should be a goal of reform.

In addition, 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.

A good area to begin improvements in knowledge about the effectiveness of medical care would be with prescription drugs. Realistically, any prescription drug benefit will require efforts to hold down costs over time. Part of that effort needs to be based on evidence of the

comparative effectiveness of various drugs, for example. Establishing rules for coverage of drugs should reflect good medical evidence and not just on which manufacturer offers the best discounts. Undertaking these studies and evaluations represents a public good and needs to be funded on that basis.

Within the fee-for-service environment, it would be helpful to energize both patients and physicians in helping to coordinate care. Patients need information and support as well as incentives to become involved. Many caring physicians, who have often resented the low pay in fee for service and the lack of control in managed care, would likely welcome the ability to spend more time with their patients. One simple way to do this would be to give beneficiaries a certificate that spells out the care consultation benefits to which they are entitled and allow them to designate a physician who will provide those services. In that way, both the patient and the physician (who would get an additional payment for the annual or biannual services) would know what they are expected to provide and could likely reduce confusion and unnecessary duplication of services that go on in a fee for service environment.

Additional flexibility to CMS to manage and develop payment initiatives aimed at using competition where appropriate also could result in long term cost savings and serve patients well. In the areas of durable medical equipment and perhaps even some testing and laboratory services, contracting could be used to obtain favorable prices.

These are only a few examples of changes, none of which promise to be the magic bullet, but which could aid the Medicare program over time.

CONCLUSION

Not only is Medicare a viable program, it is important to work hard to keep it that way. 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. But that does not imply that such additional revenues are beyond our grasp. Medicare now serves one in every seven Americans; by 2035 it will serve nearly one in every four. And these people will need to get care somewhere. If not through Medicare, then where?

The information provided in this testimony is discussed in more detail in the following three publications:

Cristina Boccuti and Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," *Health Affairs* Vol. 22, March/April 2003, pp. 230-237.

Marilyn Moon and Matthew Storeygard, "Solvency or Affordability? Ways to Measure Medicare's Financial Health," Henry J. Kaiser Family Foundation, March 2002.

Stephanie Maxwell, Marilyn Moon, and Misha Segal, "Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries," The Commonwealth Fund, January 2001.

A PRIMER FOR JOURNALISTS ON MEDICARE REFORM PROPOSALS

Uwe E. Reinhardt, Ph. D.
Princeton University
reinhard@princeton.edu
tel: 609-924-7625 or 609-258-1456 or 609-258-4781

March 3, 2003

From time to time, President Bush has offered observations on the imperative of reforming the Medicare program. He did so in his *State of the Union Address* and in the follow-up address in Michigan. He did so again on March 3, 2003 in his address to the American Medical Association entitled "*21st Century Medicare: More Choice—Better Benefits.*"

In this endeavor, the President builds on ideas initially advanced in the journal *Health Affairs* by Brookings economists Henry Aaron and Robert Reischauer, who in the mid-1990s, offered the outlines of a premium-support model for Medicare based on managed competition among private health plans¹. These ideas subsequently informed the work of the *Bi-Partisan Commission on the Future of Medicare*, which, however, did not have a majority vote to support the proposal before it. The *Commission's* proposal was subsequently introduced as a bill in the Senate by two members of the *Commission*, Senators John Breaux (D-LA) and Bill Frist (R-TN). It is known in the literature as *Breaux-Frist I*. A subsequent bill authored by the two Senators, called *Breaux-Frist II*, focused not on an overall Medicare reform, but mainly on adding prescription drug coverage, which the authors of the bill would have included in both the traditional Medicare program and the *Medicare+Choice* program established with the *Balance Budget Act of 1997*.

Because the President's proposal remains at the level of highly abstract sketches of a mere framework for Medicare reform, it would be premature to comment on it in detail, other than its main thrust, which appears to be a set of tax-financed financial incentives for Medicare beneficiaries deliberately tilted in favor of private health plans. Therein lies the plan's most controversial feature.

In the following primer on Medicare reform, I focus initially on the shortcomings of the traditional Medicare program and their origin. Thereafter I comment on the nature of choice and the style of competition that might be offered by Medicare reform and on the diverse goals the authors of Medicare reform proposals may have in mind. The objective is not to proffer one or the other proposal, but merely to provide for journalists a framework that might help them formulate targeted questions on this issue.

¹ Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What is the next Step?" *Health Affairs* (Winter, 1995): pp. 8-30.

A. THE SHORTCOMINGS OF THE TRADITIONAL MEDICARE PROGRAM

The traditional Medicare program, which was passed into legislation in 1965, still covers over 80 percent of the 40 million or so Medicare beneficiaries. The program remains highly popular among Medicare beneficiaries and their children. In surveys on consumer satisfaction with how well various insurance products or carriers satisfy consumers, the Medicare program invariably receives among the highest and often the highest satisfaction scores.² It appears to be so, because Medicare is administratively simple from the beneficiary's perspective and offers them a sense of *permanent security*—health insurance that one cannot lose. Furthermore, most Medicare beneficiaries have supplementary insurance to cover the gaps in the traditional Medicare benefit package.

What is proposed to be reformed, then, is a government-run program that remains highly popular among the citizenry, even if not among all policy analysts and policy makers. To understand better the current imperative of reform, it is well to explore why this inherently popular program has the shortcomings attributed to it and precisely who should be blamed for these shortcomings. My short answer is that the main culprit is not the much maligned bureaucracy administering Medicare, but its Board of Directors: the Congress of the United States.

The Critics of Medicare: The critics of Medicare—chiefly market-oriented policy analysts and policy makers—call the program hopelessly “outdated.” To quote from the President's recent press release entitled “21st Century Medicare: More Choices—Better Benefits” (March 3, 2003):

As successful as Medicare has been, it has not kept pace with decades of dramatic improvements in health care delivery. As a result, Medicare today does not provide the benefits and choices that are available to many other Americans. The program lacks an outpatient prescription drug benefit, full coverage of many preventive benefits, and protection from high out-of-pocket costs.

This assertion is certainly valid. The question raised earlier, however, remains: Why is that so? Why were such large gaps in coverage left when the program was passed in 1965? And why has the program not been modernized in step with medical developments?

Gaps in Coverage at Medicare's Inception: When Medicare began its life in 1965, it was expressly designed to be a *passive* adaptation to these standards set by private health insurance. Consequently, Medicare did not cover prescription drugs at its inception in 1965 because, at that time, private health insurers typically did not cover prescription drugs either. In fact, private insurers

² See, for example, Davis et al., “Medicare Versus Private Insurance: Rhetoric and Reality,” *Health Affairs Web Exclusive*, October 9, 2002. In surveys by the Kaiser Family Foundation Medicare also received very high marks by both Medicare beneficiaries and younger respondents. See Henry J. Kaiser Family Foundation and Harvard School of Public Health, *National Medicare Policy Options Survey* (Menlo Park and Boston: Kaiser/Harvard, 1998), available on the website www.kff.org.

began coverage of prescription drugs only in the early 1990s. Until then, drugs did not play nearly the important role in clinical therapy that they do today.

Similarly, private plans typically did not cover preventive care. Finally, private insurers in those days were mere bill payers. They would not have dreamt of interfering in the ongoing doctor-patient relationship (i.e., to “manage” care), and they paid each doctor and hospital their “usual, customary, reasonable” (UCR) fees, without any explicit bargaining over price discounts. With very few exceptions, most private insurers simply paid whatever bill was submitted to them. Cost control was not needed, because no one (especially employers) asked for it.

Initially, Medicare, too, paid providers each their “usual, customary and reasonable fees,” or retrospectively covered each provider’s full cost. Furthermore, Medicare was specifically forbidden to interfere with the doctor-patient relationship in the way that is common under modern managed care. The very idea of “disease management” was anathema to physicians at the time, even for patients under private health insurance.

As noted, only in the 1990s did most private insurers begin to cover prescription drugs and to “manage” care through direct interventions in ongoing therapies. It was made possible by selective contracting by insurers with a limited number of doctors, hospitals and other providers, which gave insurers economic leverage over the selected providers. The ability not to do business with certain providers allowed insurers to bargain with providers over price discounts, and it also made providers put up with controls on utilization, through primary-care gate keepers for specialist care, pre-authorizations of costly procedures, practice guidelines or refusals to pay for services rendered. Congress has never allowed Medicare to engage in selective contracting of this sort.

The Failure to Modernize Medicare: For starters, the common accusation that Medicare has not been innovative is only partly true. In some areas, it has been a world leader in innovation.

During the 1970s, for example, Medicare initiated break-through research on the payment of hospitals and physicians, which led to major practical innovations in the 1980s and early 1990s. As early as 1983, Medicare introduced the case method of payment for hospital care (based on *Diagnostically Related Groupings* of medical cases, or DRGs), a system that has in the meantime been copied in many other countries—notably in France, in Australia and now Germany. In the early 1990s, Medicare developed and introduced the *Resource Based Relative Value Scale (RBRVS)*, which underlies the current Medicare fee schedule for the payment of physicians and has been widely adopted by private insurers in the United States as a basis for negotiating fees for physicians. Further payment reforms have been instituted recently in outpatient hospital care and in home- and skilled nursing care. These innovations required major breakthroughs at the intellectual level and in policy implementation.

It is true, however, that the traditional Medicare program did not adopt any of the managed care techniques introduced by private insurers in the 1990s, nor did it modernize the program’s benefit package to include drug therapy and catastrophic care. It is, therefore, eminently fair to call

the traditional Medicare program "old-fashioned," "outdated" and "out of tune with modern clinical practice." Once again, however, it is also fair to ask why this is so.

Who Bears the Blame for Medicare's Shortcomings? When politicians or other critics of Medicare call Medicare outdated and not sufficiently innovative, they tend to imply that these shortcomings mirror the shortcomings of the "unwieldy, incompetent government bureaucracy" that administers Medicare. That explanation has resonance among the citizenry and among pundits, but it is a bum rap.

The fault in this regard lies not with the Medicare bureaucracy. Fair observers will trace these shortcomings almost wholly to Medicare's Board of Directors, notably the *House Ways and Means Committee* and the *Senate Finance Committee* of the Congress of the United States. Together, these two committees form the bulk of the Board that governs the vast insurance company called Medicare. As Boards of Directors of an insurance company go, Congress performance in this role has not been impressive.

That Board (Congress), for example, allows Medicare an administrative budget of less than 2% of total expenses. It can be doubted that any private insurance company could administer so vast a program properly at such a low overhead expense ratio.

Similarly, the Board (Congress) allows Medicare to spend only \$15 million (yes, *million*) on operations research, which is to cover both the Medicare program and the Medicaid program for the poor. As a percentage of the total \$400 billion or so spent on these two programs, the Board's (Congress') allocation for operations research amounts to 0.0038% of total spending. Can one imagine the Board of any business firm constraining the firm's operations research budget in this truly scandalous way?

In short, is it any wonder that Medicare has had trouble managing the program, even if it were allowed by Congress to be innovative? It can be argued that, if this Board were in the private sector, its mode of governance would be subject to serious review and severe sanctions by the authorities. In a nutshell, the following can fairly be asserted:

If the traditional Medicare program does not cover prescription drugs, it is so because the Congress of the United States has willed it so.

If the traditional Medicare program does not work as a prudent purchaser with selective centers of excellence or with other preferred providers known to give cost-effective care, it is so because Congress has expressly forbidden that kind of contracting and prudent purchasing.

If the traditional Medicare program does not engage in "disease management" or "managed care" of any type, it is so because Congress has willed it so.

If the traditional Medicare program has hardly ever had the benefit of being able to solicit competitive bids for the products and services it purchased on behalf of seniors, it is so because the Congress has willed it so.

Think of a major shortcoming of the traditional Medicare program, and it will typically turn out that the shortcoming exists because the Congress has consciously and deliberately willed its existence. Journalists would be well advised to inquire of members of Congress why this should be so.

B. WHAT "CHOICE" AND WHAT STYLE "COMPETITION"?

Americans take it for granted, and economists agree, that, where feasible, government-run programs should be subjected to competition from private-sector entities offering at least the same benefits. For these two reasons, one should welcome any reform that sets up a *fair* and *intellectually manageable* competition between the traditional Medicare program and equivalent private-sector health insurance products.

There also seems to be widespread acceptance of the premise that "more choices" is always to be preferred to "fewer choices" in the design of social programs. Modern behavioral economists, however, would warn us that there can be such a thing as too much choice. It happens when choices set before individuals are not accompanied by adequate information on these choices. It also happens when the sheer complexity of the choice menu overwhelms the individual's capacity to make rational choices.

If the Administration and the Congress wish to confront Medicare beneficiaries—especially the frail elderly—with ever more complex choices in health insurance, it is incumbent upon government to accompany these choices with clear information about them and to structure them so as to make rational choice manageable by ordinary human beings.

In this regard, one is not at all assured by the recent headline that "Medicare Officials Order End to Instructive Services" (The New York Times, January 25, 2003, p. A12). The article opens with the statement:

"Running short of money, Medicare officials have ordered immediate cuts in a wide range of services that provide information, advice and assistance to Medicare beneficiaries."

If this is an augury to come for Medicare reform, then "more choice" may well end up as "more confusion" and "more regret" *ex post*. As noted earlier, the blame for this policy rests solely on the Administration and the Congress, which jointly set Medicare's administrative budget. **Consequently, it is proper for reporters to query representatives of these branches of government sharply on this facet of Medicare reform.**

Choice of what? In thinking further about "more choice" for Medicare beneficiaries, a distinction should be made among (a) choice among alternative insurance products, (b) choice among doctors, hospitals and other providers of health care, and (c) choice among alternative therapeutic strategies (including drug therapies).

Since about the mid 1980s, Medicare has afforded its beneficiaries at least some choice among insurance products—most expressly so since passage of the *Balance Budget Act of 1997* (BBA '97), which established the *Medicare+Choice* program. That choice, however, is now said to have been hampered by the payment structure Congress had imposed on it in the BBA '97.

Medicare beneficiaries have always had the freest conceivable choice among providers of health care in the United States. It is hard to imagine how that choice could be enhanced by any reform.

Finally, Medicare recipients and their physicians have always had completely unfettered Choice among therapies, although not all components have been covered by Medicare, which indirectly limits choice. In principle, the problem could be solved simply by legislating their inclusion in the traditional Medicare benefit package. The problem is not an immutable state of nature. It is of Congress' own making.

The Fairness of Competition: The next question is what form the competition should take. Two distinct visions of this competition are now put before the American people.

One arrangement would be to style the choice and competition among health insurance products as one between (a) a *modernized*, government-run Medicare program that includes prescription drugs, preventive care and catastrophic coverage, and that is allowed by Congress to use techniques of modern "managed care" and (b) equivalent private-sector insurance products managed by private health plans. The arrangement would attempt to create a level playing field between a government-administered Medicare and private-sector competitors.

An alternative arrangement—one deliberately designed to erode the popularity of the traditional Medicare program—is to style the choice and competition in Medicare as one between (a) the traditional, unreformed, government-run Medicare program, whose development has been and will continue to be deliberately stunted by the Congress and (b) more modern private-sector insurance products offered by private health plans. It appears to be the style of competition preferred by the President, who would endow the traditional Medicare program with only a skimpy drug benefit³ and subsidize drug benefits through private plans more heavily, and who would otherwise not alter Medicare's benefit package.

No one, not even its proponents, would call this proposal *fair* competition. It is the analogue of a parent offering a high school graduate, as a graduation gift, a choice between (A) a Ford Taurus and (B) a similar Chevrolet, on the condition that the parents will pay for a CD player in the Ford Taurus and pick up the annual maintenance costs on it, but that they will not cover these items for the

³ Medicare beneficiary choosing to stay in the traditional Medicare program would receive free of charge a drug-discount card—presumably administered by a pharmaceutical benefit management company or a private insurance carrier—to benefit from bulk purchasing. They would also have catastrophic coverage for drug spending exceeding an annual threshold, which is left unspecified. Low income beneficiaries would, in addition, receive a \$600 annual subsidy toward their drug purchases.

Chevrolet. It can be doubted that either GM or the kid would call this a fair choice. In this analogue, the President would be seen simply to favor the Ford Taurus, period.

The question thus arises what rationale one might offer for styling the competition between Medicare and substitute private health plans in this unfair way. It is a question reporters would be well advised to probe.

First, it might be argued that, under our system of political governance and campaign financing, it will always be impossible to modernize Medicare in step with changes in modern medicine. The argument would be that Congress and successive Administrations have managed Medicare sloppily because, by its very nature, American government manages everything it does sloppily. It is a troublesome thought, especially at a time when the nation embarks upon a government-run war and upon government-run nation building abroad. Yet that thought appears to have much currency in this country at this time.

Second, it may be argued that government-run health insurance programs are inherently cumbersome, because they must strive to be *horizontally fair* to all parties, while market mechanisms usually are not subject to that constraint, unless government imposes on them. To illustrate, Medicare must observe scrupulously horizontal equity in its dealings with hospitals and physicians. (Horizontal equity means two physicians or hospitals would always be treated the same way). There are public hearings on proposed changes, notices in the Federal Register, comment periods, and such. By contrast, private health plans need not be so fair. They can treat different physicians differently, if they can cut different deals with them, and they can change rules or contracts with providers and patients overnight, without much notice, and subject only to the tort system and contract law. Therein lies greater flexibility.

A **third** argument for the proposed, unfair competition might be that, by their respective natures, private health insurance plans will always be more *efficient* than government-run insurance plans in anything they do. In principle, that hypothesis is amenable to empirical verification, after one has defined carefully what is meant by "efficient." If there is a body of empirical research that convincingly supports this hypothesis (which there might be) I am not aware of it. **In any event, it is proper and, indeed, important to challenge proponents of this style of competition to adduce a convincing body of empirical evidence (not just one study) to support this hypothesis, if that is what drives the preference for this unfair form of competition.**

Fourth, one may prefer styling the competition in this unfair way simply with appeal to ideological aesthetics—that is, because one likes the private sector better than the public sector, whatever their relative efficiencies may be.

The Forthcoming Debate: The forthcoming debate over Medicare reform will be largely over these two alternative forms of choice and competition for Medicare.

If, in their wisdom, the Administration and the Congress decide not to allow the government-run Medicare program to modernize its *modus operandi* in any way—e.g., not to include a

comprehensive prescription drugs in its benefit package—then that decision amounts to a slow-death sentence for the traditional Medicare program—especially as more and more business firms cut away at their retiree-health benefit packages, which now typically include drug coverage.

It is a choice a nation can rationally make, of course. But if that were the goal of any proposed Medicare reform, it should be openly acknowledged and debated in a properly functioning democracy.

C. EVALUATING MEDICARE REFORM PROPOSALS AGAINST THEIR GOALS

Whether a health reform proposal will “work” depends crucially on what goal one seeks to achieve with it. Remarkably, the debate on Medicare freeform is intolerably vague on the matter of goals. Often they are merely implicit in the debate, if not carefully camouflaged.

Reporters following this debate should be persistent in extracting from the various camps the specific goal or goals they would posit for Medicare reform. Prominent among these goals might be

- Reduction in total health spending per Medicare beneficiary, from all sources, however it may be split between taxpayers and Medicare beneficiaries.
- Reduction only in the taxpayer’s exposure to Medicare spending, even if it increased total health spending per Medicare beneficiary.
- Obtaining better value for the health care dollar, whatever the source, and whatever Medicare reform does to total health spending per Medicare beneficiary, from whatever source.
- Rescuing the private health insurance from a slow death march caused by the ever-finer risk segmentation that occurs under mass customization of private health insurance.

One can think of yet other objectives—for example, the fourth rationale spelled out toward the end of the previous section. In what follows, I elaborate on these four goals.

GOAL 1: REDUCTION IN TOTAL HEALTH SPENDING PER ELDERLY

Many people seem sincerely to believe that a Medicare reform will help the nation substantially to lower the total economic burden that future health spending on the growing number of elderly will impose on the economy. I have serious doubts that this goal can be achieved. In all likelihood, the reform would merely redistribute that growing burden from taxpayers to Medicare beneficiaries.

Think about it. The nation’s total health spending on its elderly population in future years is tautologically the product of (a) the total number of elderly in the various age-gender categories times (b) the age-specific health spending per capita for the respective age-gender categories.

Reforming Medicare cannot change future demographic trends perceptibly⁴. It follows that Medicare reform could affect total national health spending on the elderly only by changing average age-gender specific health spending per capita. Specifically, people who argue that a Medicare reform, along the lines proposed in *Breaux-Frist I* or the President's March 3rd sketch, will lower the overall economic burden that health care for the elderly will place on our economy would have to demonstrate convincingly that under a privatized Medicare program the average per-capita health spending for, say, 75-year old females in 2020 would be lower than it would be under continuance of the traditional Medicare program.

Is this scenario plausible? Surely it is fair to ask this question at a time when even large employers—including CalPERS, that allegedly most savvy purchaser of health insurance—face premium increases for private group health insurance policies in the mid to high double digits? These numbers do not inspire confidence on the matter of cost control.

Let us probe this matter further. A reduction in the total health spending per Medicare beneficiary, from whatever source, implies that either (a) the volume of services rendered these beneficiaries, or (b) the prices paid for them, or (c) both, must decrease relative to the volume and the prices that would obtain for the same beneficiaries under the traditional, government-run Medicare program. How realistic is that expectation?

Lower Prices? Is it reasonable to suppose that private health plans will be able to procure health care from doctors, hospitals and other providers at lower fees than those the traditional, government-run Medicare has been able to achieve? I would rate that chance slim to nil.

In all likelihood, the plans would have to pay higher prices. Indeed, Medicare reform proposals often are pitched to doctors and hospitals on the promise that private insurers will pay them better than does traditional Medicare. (A test of that prospect might be how the providers react to the President's proposal. If they favor it, we can bet that they expect to receive higher fees from the plans).

The fact that the premiums charged by private insurance plans to employers now rise at double-digit annual rates is added reason to doubt that the private plans would have more market clout in bargaining over fees than does Medicare.

Lower Utilization? If the health plans will not be able to buy health care for the elderly at lower fees and yet total health spending on the elderly is to fall, then all of that reduction in spending must come from reductions in utilization of real health care services.

Such reductions may well be possible and clinically defensible. Unfortunately, to achieve those reductions in utilization, the health plans would have to put into effect precisely the

⁴ Purists may argue that better management of Medicare might alter mortality rates, and so forth; but that would trigger at best an imperceptible change in future demographics.

managed-care techniques that were so vehemently opposed by doctors and patients (and the Congress) and that brought on the managed-care backlash among employed Americans.

In fact, one can only imagine what sort of backlash physicians might be able to trigger—in the face of traditionally unaccustomed utilization controls for Medicare patients—if they can use the elderly as the megaphones for their opposition.

Journalists might question proponents of privatizing Medicare on this point. Do the health plans have in mind techniques of lowering the use of health services by means other than the managed care techniques of yore? If so, what would they be, and what would them more acceptable to doctors and patients. Furthermore, are they now operative anywhere in the U.S. on sufficiently large scale to inspire confidence?

Lower Overhead? As noted above, Medicare itself now spends less than 2% of its total outlays on administrative expense. There are no marketing expenses to speak of and, of course, no profits for shareholders to cover out of premium income. To this Medicare expense ratio, however, must be added the additional administrative and marketing expenses, and profits, currently included in the premiums for the *Medigap* policies carried by most Medicare beneficiaries. Presumably, a privatized Medicare benefit package would cover what traditional Medicare plus *Medigap* policies now cover combined.

Unfortunately, there is no evidence that a privatized Medicare would reduce the total overhead for administration, marketing and profits per beneficiary relative to the cost of these items under traditional Medicare plus *Medigap*. They may easily cost more. **It is a question reporters might probe with proponents of Medicare reform: do these proponents have convincing empirical evidence that privatizing Medicare will reduce the fraction of total health spending per elderly devoted to marketing, administration and profits?** (In insurance jargon, we would talk about the *Medical Loss Ratio (MLR)*. It is the fraction of the total premium for health insurance paid out for medical benefits. The question then is whether privatizing Medicare would increase the *MLR*, i.e., reduce the fraction devoted to marketing, administration and profits).

Boot up website www.kff.org and search for the chart book *Trends and Indicators in the Changing Health Care Marketplace*, 2002 (May 2002). As is shown in Exhibit 3.8 of that handy chart book, the annual growth rates in per-capita health spending under private health insurance and under Medicare seesaw over the long haul. During 1980-84, for example, the Medicare growth rate exceeded the private-sector growth rate. From 1985-1992, private-sector growth exceeded substantially the growth in per-capita Medicare spending. During 1993-97, the trends had flip-flopped once again. Since 1998, private sector growth has, once again, exceeded the growth in per-capita Medicare spending by quite some margin.

Prognosis on Cost Containment: In short, I am not persuaded by the historical empirical evidence that private health plans actually can control the annual growth in per-capita health spending consistently better than has the traditional Medicare program. Whatever the virtues of privatizing Medicare may be, history provides reason to doubt that lowering the total burden of health spending for the elderly (from all sources) in the decades ahead is unlikely to be one of these virtues.

Unless medicine itself comes up with major labor-saving breakthroughs in clinical therapy (e.g., through novel drug therapy, including pharmacogenomics and gene therapy, or novel devices), we seem to be more or less stuck with the future economic burden imposed on us by demography. We can at best reshuffle its incidence among the American people which, I believe, is what Medicare reform is all about.

Journalists should demand of anyone who would argue otherwise a body of scientific, peer-reviewed empirical evidence (not just one or a few studies commissioned by special interest groups from compliant consulting firms) that consistently and persuasively supports the contrary view.

GOAL 2: REDUCTION MERELY OF THE TAXPAYER'S EXPOSURE

An alternative goal for Medicare reform might to construct a legislative platform that would enable future Congresses to limit the taxpayer's exposure to increases in total health spending per beneficiary, whatever the trend in total spending might be, and to let the elderly bear the risk of future health-care cost inflation. **I have the impression that tacitly many proponents of privatizing Medicare really have this goal in mind, even though it may not be politically correct actually to say so.**

The argument here would be that, with only 2.2 workers per elderly in 2020 (versus 3.8 now), the elderly must be forced to pay a higher fraction of their own health care costs out of their own pockets. Under the current, *defined-benefit* structure of Medicare, such a cost shift would have to be made explicitly and therefore might trigger a political reaction from the elderly. Privatizing Medicare would implicitly convert Medicare into a defined-contribution model, which would enable Congress to achieve that cost shift much more gradually, over time, in subtle ways designed to avoid a sharp political reaction from the elderly.

As noted, at the moment it is not yet politically correct to articulate this goal openly. It is therefore discussed in code words—such as vague references to the “fiscal sustainability of Medicare.” In the President's sketch of his Medicare reform proposal, for example, is the observation that

While Medicare must be modernized and improved to meet the needs of its current participants, the program must also be made sustainable for future generations. Given the financial challenges Medicare faces in the future, changes to the

Medicare program we make today must not exceed our nation's means to deliver them tomorrow.

Given currently projected demographic trends, it is eminently reasonable for a nation to engage in an open discourse on how the fiscal burden of caring for the nation's elderly should be shared between the elderly and the working population. But one would hope, in a proper democracy, that the idea would be forthrightly put to the electorate, if that were the goal of the proposed reform. **Journalists have a unique opportunity here to set Goal 2 bluntly before politicians and to flush them out of the closet on it: do they endorse it or not?**

Although the President's March 3rd sketch on Medicare reform is vague on the precise structure and magnitude of the financial contribution Medicare would make toward the purchase private health insurance, one gains the impression that, initially, the reform does not envisage a rigid (risk adjusted) defined contribution that would be set by Congress will appeal to its own budgetary pressures. Instead Medicare's contribution would be set as a fraction of some national average of the premiums competitively bid by the private health plans for the prescribed benefit package. (As will be argued below, however, it is not at all clear the private health plans would ever agree to competitive bidding for Medicare.)

This approach would provide future Congresses with a highly flexible platform for future changes in either direction. Congress could use that platform to freeze the fraction of the total premium charged to the elderly, and continue to leave payroll-tax and income-tax paying workers exposed to considerable risk for future cost escalation. Alternatively, the fraction of total costs charged to the elderly could be increased in subtle ways over time, either by raising the fraction explicitly, or implicitly by manipulating the base--"average premium bid"--of which the Medicare beneficiaries' share would be that fraction. A decade or so hence, the fraction could even be means formally tested, as it partially would be from the outset through larger subsidies to "low income" households.

GOAL 3: BETTER VALUE FOR THE DOLLAR

The proponents of Medicare reform might (and often do) argue that the specific intent of the reform is neither to reduce overall health spending on the elderly (Goal 1) nor even to limit the taxpayer's exposure to that spending (Goals 2), but merely to procure through superior managed-care techniques (including disease management) in the private sector an increase in the value received per dollar of total health spending on the elderly. Economists would call it an increase in *efficiency*.

This appears to be the message sent to the media by the health insurance industry. In a recent press release, for example, it was stated that:

"The unique strengths of the health plan community continue to be demonstrated in the public-private partnership of Medicare+Choice. A new Kaiser Family Foundation report shows that Medicare+Choice - despite being under funded - provides a better value to beneficiaries and lowers their out-of-pocket costs.

If greater value for the dollar were the goal of privatizing health care, then its proponents can fairly be challenged to demonstrate empirically that this efficiency would actually come about. This, then, should be the focus of the public debate on the proposal, and also the focus of media inquiries.

One yearns for this empirical demonstration because, quite frankly, the President's proposal deliberately to tilt a competition between traditional Medicare and private health plans in favor of the latter—as described earlier—gives one pause about the proposition that private health plans actually could deliver better value for the dollar in a fair competition. In the President's proposal of March 3rd, it is stated that

The President's framework will ensure that the benefits offered under Enhanced Medicare [to be offered by private health insurers] are sufficiently attractive to seniors, relative to traditional Medicare, to guarantee that Enhanced Medicare is a viable system.

Why is this necessary? To an economist, there is something both puzzling and troubling about the idea that a privatized Medicare will be "viable" only if it is bolstered by a huge, tax-financed subsidy for prescription drug coverage that would be largely denied elderly Americans who prefer to stay in the traditional Medicare program. As a long-time defender of the industry in the face of the managed-care backlash of the 1990s, I find myself on the defensive on this one. Asking government for that special favor clearly is not one of the industry's higher moments.

Journalists might probe why, if private health plans really do offer the elderly demonstrably better value for the dollar—e.g., better disease management—these plans could not attract enough elderly in a competitive world without having the competitive deck stacked artificially through a tax-financed come-on.

GOAL 4: RESCUING PRIVATE INSURERS FROM A SELF-IMPOSED DEATH MARCH

In an article on *Health Affairs's Web Exclusive*,⁵ entitled "From the Field: How and Why the Health Insurance System will Collapse," Humphrey Taylor, an astute longtime student of American health care, predicts that the risk segmentation inherent in the novel consumer-choice models in private health insurance will lead to a "death spiral of adverse [risk] selection." The thesis is that the industry's march toward ever finer risk segmentation in private insurance, under the banner of "defined contributions" and "mass customization," tends to flush out for public coverage chronically ill people who cannot afford the actuarially fair premiums that their costly medical conditions warrant and, ultimately, end up on the good mercy of government.

At this time, for example, private insurance covers only about one third of total national health spending, although it still covers about two thirds of the American population. It is so, because government programs typically cover the relatively more expensive Americans: the elderly, people on

⁵ http://www.healthaffairs.org/1130_abstract_c.php?ID=http://www.healthaffairs.org/Library/v21n6/s28.pdf

renal dialysis, the blind and otherwise disabled, pauperized Medicare beneficiaries in nursing homes, and the poor. If Americans who will be priced out of the private health insurance system through further risk segmentation were absorbed into *bona fide* government-run programs (Medicare, Medicaid and S-Chip), then a decade hence private insurers might control only about a quarter of total national health spending. This is the death spiral of which Taylor speaks.

It may well be that the private insurance industry can be rescued from that self-inflicted death spiral only if government comes to its rescue. The rescue would take the form of tax-financed subsidies for the purchase of private health insurance by Americans who could otherwise not be served by the private health insurance industry. Evidently, privatizing Medicare would be an instrument *par excellence* for achieving that goal.

Although I would not propose this goal as the sole or even the chief motive for Medicare reform, this country economist from rural New Jersey is not naïve enough to exclude it altogether from the multiple objectives pursued with privatizing Medicare. Like cash hungry-universities, who forever pass the hat to finance their sundry missions, members of Congress must forever pass the hat to fund their own reelection. In that sense, Congress can be thought of as a chronically cash hungry business enterprise and, from the perspective of that enterprise, the private health insurance industry has been and will be a much better business partner than would be the constituents arrayed around the traditional Medicare program. That circumstance may help fuel calls for Medicare reform. Certainly this hypothesis should appeal to Senator John McCain and like-minded members of Congress who see in our campaign-finance laws intolerable conflicts of interest for policy making in the Congress.

D. THE DEGREE OF EGALITARIANISM IN MEDICARE

Medicare was enacted largely by a generation that had suffered together through the Great Depression and World War II. It had come to appreciate in these experiences that good fortune in life is substantially the product of good luck, and that the spoils of good luck should be shared with less fortunate members of society. It is, therefore, not surprising that the structure of the traditional Medicare program was highly egalitarian in its intent, albeit not in practice.

Within the benefit package covered by Medicare, the program is, indeed, highly egalitarian. Every beneficiary is entitled to the same covered benefits, regardless of socio-economic status. Every beneficiary has the same free choice of provider within the relevant market area. Every provider in the relevant market area is paid the same fee for a particular service, regardless of the recipient's socio-economic circumstance, and providers may not bill significant fees on top of the Medicare fee (if any at all). By contrast, society's valuation of physician's work for, say, children, varies considerably with the child's. If a state legislator is willing to budget only \$10 per pediatric visit for a child covered by Medicaid, but \$60 for his or her own child covered by his or her private insurance, then that legislator inevitably signals the physician a clear message on the relative valuation of work devoted to the Medicaid child and to the legislator's own child.

Within the confines of the covered benefit package, Medicare thus is as exquisitely egalitarian as those of the Canadian provincial health plans or of Germany's sickness funds. The problem all along has been that the limited benefit package of traditional Medicare precludes a completely egalitarian sharing of the total health care experience among the elderly. A well-to-do beneficiary, or one with generous employer-paid *Medigap* coverage, for example, will have a quite different health care experience in the face of a given illness than does a low-income beneficiary without drug coverage, and similarly for other uncovered services.

Without much greater specificity on the actual design parameters of Medicare reform, it is impossible to assess how it might alter the overall degree of egalitarianism in the provision of health care to America's elderly (and other Medicare beneficiaries). By itself, the broadened benefit package promised by the reform would be scored as an increase in egalitarianism. On the other hand, the *defined-contribution* feature incorporated into the reform and the choice among many, customized private insurance products would be scored as a likely decrease in the overall egalitarianism of the health care experience of elderly Americans (and other beneficiaries).

On the issue of egalitarianism score, then, the jury is still out. Journalists, however, might keep the issue in sight, probe deeply into their findings to the public, when the time comes to be more specific. It would be entirely appropriate, for example, to grill a proponent of a particular reform to make explicit his or her assessment of the impact of the proposed reform on this aspect of a health care arrangement for Medicare beneficiaries.

E. SOME MAJOR OBSTACLES FACING MEDICARE REFORMERS

The proposed reform would face a number of technical and political problems in addition to those raised above, some of which already had surfaced under the Clinton Plan.

Competitive Bidding: A central idea underlying many Medicare reform proposals—including the President's current proposal of March 3, 2003—is that private health plans would bid their premiums competitively for a specified benefit package for Medicare beneficiaries. If history is any guide, this is much easier said than achieved.

During the past decade the then Health Care Financing Administration (HCFA)—and now Centers for Medicare and Medicaid Services (CMS)—had tried on numerous occasions to experiment in a few markets with competitive bidding by private managed-care plans for Medicare beneficiaries. Each and every time the experiment was abolished, at the behest of the private health plans, and through the good offices of Medicare's Board of Directors, the Congress.⁶

⁶ In this connection see the entire section entitled "Medicare Reform" in *Health Affairs* (September/October, 2000), pp.8-59, especially the paper by Bryan Dowd *et. al.* "A Tale of Four Cities: Medicare Reform and Competitive Bidding."

Reporters are entitled to wonder why things would be different in the future and they should probe that issue vigorously. What evidence is there that the private insurance industry will ever accede to competitive bidding for so large a clientele as Medicare?

My prediction is that private health plans would instead plead for administered prices. From the perspective of the industry, administered prices have two advantages. First, they can be more easily influenced through the political process. Second, they can be used as a scapegoat whenever something goes wrong with Medicare beneficiaries.

The Wennberg Variations: The President's proposal might also flush into better view the enormous regional variations in Medicare spending per statistically equivalent elderly.⁷ Although the President's reform proposal might be viewed as an attempt to eliminate that variation through competitive market forces, for a while (perhaps a decade) these variations would be likely to remain. Greater transparency on them might cause political problems.

Reporters should probe in what way a proposed Medicare reform plan—including the Presidents—will cope with the enormous regional and sub-regional variations in the average Medicare spending per statistically age-sex adjusted Medicare beneficiary.

Risk Adjustments: Like the Clinton health reform plan, the President's Medicare reform of March 3rd, 2003 requires the existence of a workable risk-adjustment mechanism that can protect individual health plans from being stuck with an unusually large number of medical risks. The adjusters are needed, because the President proposes that, once they have made their premium bids, the private health plans "will have to accept any Medicare participant wishing to enroll regardless of whether the beneficiary lives in a rural or remote area."

The risk adjusters currently used for the *Medicare+Choice* program are fairly crude and have been vehemently opposed by the private health plans. Unfortunately, the plans themselves have never proposed a superior, workable, budget-neutral alternative.

Reporters should probe precisely how any risk adjustment under competitive bidding and community-rated premiums is to work.

Insurer of Last Resort: In some Medicare reform proposals, the traditional Medicare program would be forced to compete with private health plans just like any other health plan. There is the question who will act as insurer of last resort for the elderly under such a scheme. Presumably, any private health plan serving Medicare beneficiaries at one point in time could terminate those contracts and pull out of entire regions, as the private health plans have done in the past few years under the *Medicare+Choice* program. That privilege surely would carry over to the President's plan as well.

⁷ John E. Wennberg and Megan McAndrew Cooper, *The Dartmouth Atlas of Health Care in the United States* (1999). See also their website www.dartmouth.edu/~atlas/, which exhibits these data by county.

The question arises whether, if private health plans would find serving Medicare patients in, say, certain counties in Connecticut or Iowa unprofitable and pulled out of those regions, the traditional Medicare program could also decide to pull out, or whether it would have to stay as insurer of last resort. If so, one can ask in what sense such a competition between the government-run Medicare as insurer of last resort and private health plans could be labeled "fair."

G. CONCLUSION

The purpose of this memo has not been to naysay the President's proposal, which deserves a full and fair debate, nor have I intended to sell one particular approach. I am not wedded at all to a preferred approach.

My plea merely is that in the forthcoming debate on Medicare reform we depart from empirically vacuous clichés—e.g., that the private sector is always more efficient than the public sector or, conversely, that private health plans always put "profits over people"—and that the pros and cons of the proposal be debated *forthrightly*, with appeal to the best scientific empirical evidence available on the issue.

In this regard, it is particularly important to understand why the traditional, government-run Medicare program has been left by Congress as outdated as it is. A part of the debate on Medicare reform should be why Congress has behaved in this way and why it seems determined to continue to behave in this way.

Finally, in my view, Medicare reform is unlikely to be the magic bullet that will lessen significantly, if at all, the total burden on the economy of providing health care to the nation's growing number of elderly. Medicare reform can at best limit the taxpayer's exposure to that growing burden, leaving the elderly themselves to pick up a larger fraction of the total cost of their care. It is a matter eminently worth debating at this time, but that debate should not be conducted in code words or clichés. It should be conducted forthrightly in our democracy.

APPENDIX A
AN ECONOMIC PRIMER ON MEDICARE

To think about Medicare reform, it may be helpful to distinguish between two facets of the economics of Medicare, as is done in the sketch overleaf:

1. the real resource flow of goods and services from the providers of health care to Medicare beneficiaries (the lightly shaded arrow) and

2. (the financial flows A, B and C, which transfer claims to the nation's GDP (money) from Medicare beneficiaries and taxpayers to private health-insurance carriers and thence to the providers of health care. To keep the schematic simple, Medicare itself is not shown on it, mainly because it administers the Medicare program through private health insurers who act as Medicare intermediaries.

To be explored is how Medicare reform proposals would affect the real resource flow (that is, the actual medical care going to the elderly) and the financial flow (that is, the total money reward going to the providers of health care, and the apportioning of this burden to the taxpayer and to the elderly). To think about these questions, some more commentary on these real and financial flows may be warranted.

Prices: The fees paid providers for health care rendered the elderly form the linkage between the real-resource flow in Medicare (the lightly shaded pipe) and the money pipes (A,B,C and D).

If there were only one health care service in the world – e.g., standard physician visits – then the price per visit would be simply the money flow in pipe D divided by the number of physician visits in the real resource pipe. In the real world, of course, things are much more messy, but the basic linkage remains.

It is important to keep this linkage in mind as we think about Medicare reform. If privatizing Medicare is to reduce health spending –as some proponents claim it would – then the question is how much, if any, of that reduction in spending will come from (a) reductions in fees paid providers, (b) reductions in the use of real health services by the elderly (the shaded pipe), or (c) both.

I have found it very difficult to get answers to this fundamental question from the proponents of privatizing Medicare, or from health insurance executives. Attached hereto as Appendix B, for example, is a questionnaire I once submitted to a group of health-insurance executives. With the exception of one, none of them were willing to respond to that

questionnaire. Yet an answer to this question seems fundamental, in a democracy, in the public debate on this issue.

The Medical Loss Ratio (MLR): According to the Trustees of the Medicare trust funds, Medicare currently spends less than 2% of its total outlays on administration, mainly for the work of private insurance carriers who function as Medicare intermediaries in claims processing. This means that more than 98 cents of every dollar collected by Medicare goes to the providers of health care.

It is inconceivable that a private insurer could operate at a MLR of only 98% (an administrative expense ratio of only 2%). My own estimate is that private health plans would need at least 10 cents of every premium dollar collected for Medicare beneficiaries for administration, marketing and profits.⁸ Here it must be recalled that Medicare does not have to market its products, nor pay profits to shareholders. By contrast, under the President's proposal private health plans would have to market to the elderly individually and, of course, they would have to retain some funds for their shareholders.

In fairness, it must be added that Medicare visits considerably administrative work on doctors, hospitals and other providers of health care. It is not clear, however, whether those costs borne by providers are larger for Medicare (as a percent of the providers' revenues) than are the costs they bear for processing the claims against private insurers. There is also the fact that the supplementary coverage Medicare beneficiaries purchase as a complement to the traditional Medicare coverage carries with it administrative and marketing costs that would be obviated by more comprehensive private coverage in health plans.

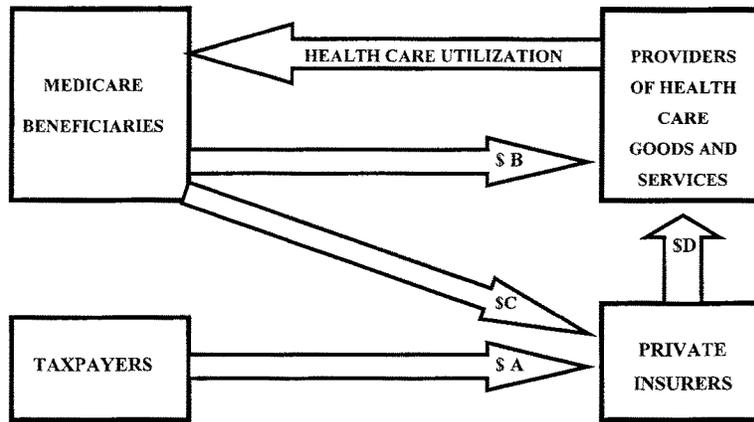
The Taxpayer's Dollar Exposure: Pipe A in the schematic represents the taxpayer's exposure for the Medicare program. It consists of the sum of (1) what we call "Medicare spending" (now roughly half of the total health spending A+B+C on the elderly, (2) Medicaid spending on the elderly and (3) other government spending on elderly American. For this purpose, we view the elderly themselves as taxpayers when they pay taxes of all sorts.

The Dollar Exposure of Medicare Beneficiaries: The sum of pipes B+C represents the exposure of the elderly for their own health care. To keep the schematic simple, pipe C is thought to include the Part B premiums paid by the elderly for Medicare coverage.

With these preliminaries, we can now turn to the question raised earlier: what benefits does the President expect from the privatization of Medicare?

⁸ See Uwe E. Reinhardt, "Perspective: Does U.S. Tax Financed Health Care Really Incur Waste?" *Health Affairs* (July/August, 2002): pp. 99-100.

THE FLOW OF REAL AND OF FINANCIAL RESOURCES IN MEDICARE



SOME FUNDAMENTAL DEFINITIONS

$\$ B$ = out-of-pocket payments by Medicare beneficiaries to providers

$\$ C$ = premiums paid by Medicare beneficiaries to private insurers (and for Part B).

$\$ A + \$ B + \$ C$ = total health spending per year on the elderly, from all sources

$\$ A + \$ C - \$ D$ = funds retained by private insurers for administration, marketing And profits

$\$ D / (\$ A + \$ C)$ = the insurers' "Medical Loss Ratio" (MLR)

$\$ B + \$ D$ = revenues received by the providers of health care

APPENDIX B

QUESTIONNAIRE FOR INSURANCE EXECUTIVES ON MEDICARE REFORM

Your name: _____ Your company: _____
 (Please print) (Please print)

SOME QUESTION ON PRIVATIZING MEDICARE A LA BREAU-FRIST I

1. According to the Trustees of the Medicare trust funds, slightly less than 2% of total spending by Medicare is currently absorbed by the program's administrative expense.⁹ My question is whether, under a privatized Medicare on the Breau-Frist I model, private health plans can manage with a similarly small load factor for administrative expenses and profits or, if not, who should pay for any extra above Medicare's 2%. To enlighten me on this point, may I ask you to respond to the following questions? Please mail your responses to Uwe Reinhardt, 351 Wallace Hall, Princeton University, Princeton, N.J. 08544. Many thanks.

a. On average, what fraction of the total premium received by your company for a Medicare enrollee (from whatever source) would your company need for

- General Administration _____%
- Marketing _____%
- Profits for shareholders _____%
-
- TOTAL _____%
-

b. If your estimated TOTAL expense ratio exceeds 2%, who, in your view, should pay for the additional cost of SG&A and profits experienced by private health plans?

- _____/ providers, through greater efficiency in the procurement of health care (i.e., lower revenue to them);
- _____/ the elderly, through commensurately higher contributions they would make toward premiums;
- _____/ the taxpayer, through higher defined contributions from Medicare paid the elderly for their health insurance

⁹ Medicare does visit considerable additional administrative costs on the providers of health care, although these costs probably are not larger, as a percentage of total revenue received, than they are for revenues received from private health insurers. While Medicare billing is predominantly electronic, many private insurers still bill on paper. Furthermore, Medicare tends to pay promptly. "Days of accounts receivable outstanding" from private insurers tend to be three to four times as high as the comparable Medicare figure.

____/ *the providers of Medigap insurance, who would lose that business because the private health plans would provider broader coverage*

____/ *all of the above, to some extent.*

2. In your view, relative to the prices at which Medicare will be able to procure health care on behalf of Medicare beneficiaries, the prices at which private health plans will be able to procure the same health care from the same providers will be

____/ lower

____/ about the same

____/ higher

3. Please assume now that the traditional Medicare program were enhanced by coverage for prescription drugs. Relative to the ***total health care cost per Medicare beneficiary*** experienced under that enhanced Medicare program (paid by whatever source, and including administrative expenses), do you believe that the comparable cost figure *for the same benefit package and for similar beneficiaries* experienced under coverage by private health plans would be

____/ lower

____/ about the same

____/ higher

4. Please assume again that the traditional Medicare program were enhanced by coverage for prescription drugs. Relative to the health care costs per Medicare beneficiary *then to be borne by the elderly* themselves under this enhanced Medicare program (i.e., their out of pocket payments at point of service plus their own contributions to premiums), do you believe that the comparable out-of-pocket spending to be borne by the aged, *for the same benefit package and for similar beneficiaries* experienced under coverage by private health plans, would be

____/ lower

____/ about the same

____/ higher

5. Open-ended question: In your view, what would be the strongest selling point to persuade *Medicare beneficiaries* that receiving their health care through private health plans would be better for them than receiving it through the traditional Medicare program (but enhanced by drug coverage).

6. Open-ended question: In your view, what would be the strongest selling point to persuade *the tax-paying public* that privatizing Medicare on the *Breaux-Frist I* model would be a good idea