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MEDICARE

Higher Expected Spending and Call for New Benefit Underscore Need for Meaningful Reform

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GAO-01-539T

Chairman Grassley, Ranking Member Baucus, and Members of the Committee:

I am pleased to be here today as you consider the need to strengthen and modernize the Medicare program. In previous testimony before this Committee, I have consistently stressed that without meaningful reform, demographic and cost trends will drive Medicare spending to unsustainable levels but that today's projected surpluses provide an opportunity to act before these trends make needed changes more painful and disruptive.

Although Medicare's short-term outlook has improved since I last testified, this should not distract us from focusing on the more important long-term perspective. The Medicare Trustees' latest projections incorporate more realistic assumptions about long-term health care spending and, as a result, the long-term outlook for Medicare's financial future has deteriorated substantially since the last Trustees' Annual Report. The Medicare Trustees and the Congressional Budget Office (CBO) now agree that spending will grow faster than was previously predicted. At the same time, the fiscal discipline imposed through the Balanced Budget Act of 1997 (BBA) continues to be challenged, while interest in modernizing the Medicare benefits package to include prescription drug coverage has increased. As a result, the need for meaningful Medicare reform is even clearer today.

We must capitalize on momentum gathering in this Committee and elsewhere to take action to adopt effective cost containment reforms alongside potential benefit expansions. It is important that any benefit expansion efforts be coupled with adequate program reforms so as not to worsen Medicare's long-range financial condition. Ultimately, any comprehensive Medicare reform must confront several fundamental challenges. In summary:

- Our long-term budget simulations show that demographics and health care spending will drive projected long-term deficits and debt. Our January 2001 long-term simulations show that even if all unified surpluses are saved—which no one expects will occur—large and persistent deficits will return in the long term absent policy change.

- Medicare spending is likely to grow faster than previously estimated. The Medicare Trustees are now projecting that, in the long- term, Medicare costs will eventually grow at 1 percentage point above per-capita gross domestic product (GDP) each year—about 1 percentage point faster than the previous assumption. Accordingly, as estimated by the Office of the

Actuary at the Health Care Financing Administration, (HCFA), the estimated net present value of future additional resources needed to fund Part A Hospital Insurance (HI) benefits over the next 75 years increased from $2.6 trillion last year to $4.6 trillion—an increase of more than 75 percent.

- Measurement of Medicare's sustainability can no longer be merely the traditional measure of HI Trust Fund solvency that has been used to assess the program's financial status. Both Part A expenditures financed through its Trust Fund and Part B Supplementary Medical Insurance (SMI) expenditures financed through general revenues and beneficiary premiums must be taken into consideration.

- Since the cost of a drug benefit will boost these spending projections even further, adding drug coverage under Medicare's already dark financial cloud will require difficult policy choices that will likely have a significant effect on beneficiaries, the program, and the marketplace.

- Properly structured reforms to promote competition among health plans can help make beneficiaries more cost conscious. However, improvements to traditional fee-for-service (FFS) Medicare are also critical, as it will likely remain dominant for some time to come.

- Fiscal discipline is difficult, but the continued importance of traditional Medicare underscores the need to base adjustments to provider payments on hard evidence rather than anecdotal information and to carefully target relief where it is both needed and deserved.

- Reform of Medicare's management, which is on the table as discussions of Medicare program reforms proceed, similarly will require carefully targeted efforts to ensure that adequate resources are appropriately coupled with increased accountability.

- Ultimately, we will need to look at broader health care reforms to balance health care spending with other societal priorities. In doing this, it is important to look at the entire range of federal policy tools—tax policy, spending, and regulation. It is also important to note the fundamental differences between health care wants, which are virtually unlimited, from needs, which should be defined and addressed, and overall affordability, of which there is a limit.

The new consensus that Medicare is likely to cost more than previously estimated serves to reinforce the need to take prompt action. Realistically, reforms to address the Medicare program's huge long-range financial imbalance will need to proceed incrementally. In addition, efforts to

update the program's benefits package will need careful and cautious deliberation. This is especially important in connection with a potential prescription drug benefit, as this coverage represents one of the fastest-growing expenditures for public and private health plans. Therefore, the time to begin these difficult, but necessary, incremental steps is now.

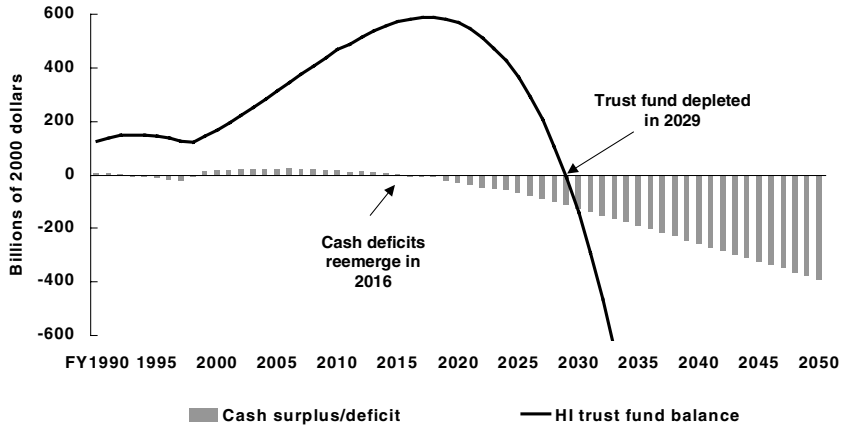
Medicare's Long-Term Outlook Has Worsened

As I have previously testified before this Committee, Medicare as currently structured is fiscally unsustainable. While many people have focused on the improvement in the HI Trust Fund's shorter-range solvency status, the real news is that Medicare's long-term outlook has worsened significantly during the past year. A new consensus has emerged that previous program spending projections have been based on overly optimistic assumptions and that actual spending will grow faster than has been assumed.

Traditional HI Trust Fund Solvency Measure Is a Poor Indicator of Medicare's Fiscal Health

First, let me talk about how we measure Medicare's fiscal health. In the past, Medicare's financial status has generally been gauged by the projected solvency of the HI Trust Fund, which covers primarily inpatient hospital care and is financed by payroll taxes. Looked at this way—and based on the latest Trustees' report—Medicare is viewed as solvent through 2029. (See fig. 1).

Figure 1: Medicare's Hospital Insurance Trust Fund Faces Cash Deficits as Baby Boomers Retire



Note: Projections are based on the intermediate assumptions of the 2001 HI Trustees' Report.

Source: GAO analysis of data from the Office of the Actuary, Health Care Financing Administration.

However, HI trust fund solvency does not measure the growing cost of the Part B Supplementary Medical Insurance (SMI) component of Medicare, which covers outpatient services and is financed through general revenues and beneficiary premiums. Part B accounts for somewhat more than 40 percent of Medicare spending and is expected to account for a growing share of total program dollars.

In addition, HI trust fund solvency does not mean the program is financially healthy. Although the trust fund is expected to remain solvent until 2029, HI outlays are predicted to exceed HI revenues beginning in 2016. As the baby boom generation retires and the Medicare-eligible population swells, the imbalance between outlays and revenues will increase dramatically. Thus, in 15 years the HI trust fund will begin to experience a growing annual cash deficit. At that point, the HI program must redeem Treasury securities acquired during years of cash surplus. Treasury, in turn, must obtain cash for those redeemed securities either through increased taxes, spending cuts, increased borrowing, retiring less debt, or some combination thereof.

Clearly, it is total program spending—both Part A and Part B—relative to the entire federal budget and national economy that matters. This total

spending approach is a much more realistic way of looking at the combined Medicare program's sustainability. In contrast, the historical measure of HI trust fund solvency cannot tell us whether the program is sustainable over the long haul. Worse, it can serve to distort the timing, scope, and magnitude of our Medicare challenge.

New Estimates Increase Urgency of Reform Efforts

Besides looking at total program spending, any assessment of Medicare's financial condition must acknowledge that absent meaningful program reforms, program cost growth will likely be greater than has been previously projected. A technical panel advising the Medicare Trustees recently recommended assuming that future per-beneficiary costs for both HI and SMI eventually will grow at a rate 1 percentage point above GDP growth—about 1 percentage point higher than had previously been assumed.[1] That recommendation was consistent with a similar change CBO made to its Medicare and Medicaid long-term cost growth assumptions last year.[2] In their new estimates published on March 19, 2001, the Trustees adopted the technical panel's long-term cost growth recommendation.[3] The Trustees note in their report that this new assumption substantially raises the long-term cost estimates for both HI and SMI. In their view, incorporating the technical panel's recommendation yields program spending estimates that represent a more realistic assessment of likely long-term program cost growth. (See fig. 2.)

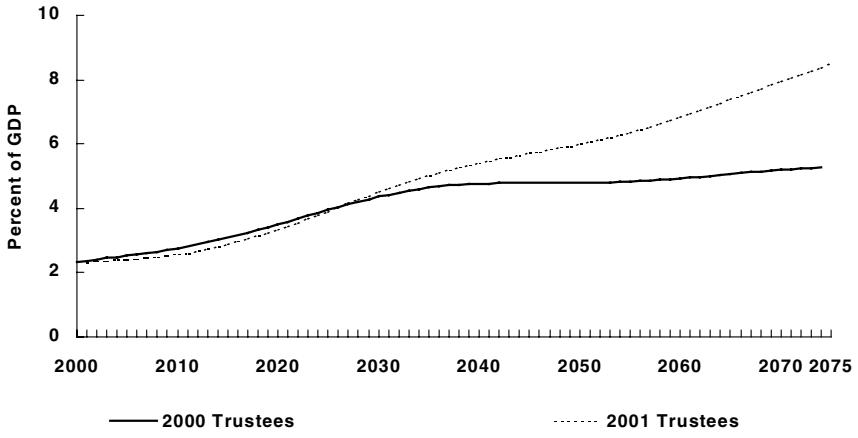
Under the old assumption (the Trustees' 2000 best estimate intermediate assumptions), total Medicare spending consumes 5 percent of GDP by 2063. Under the new assumption (the Trustees' 2001 best estimate intermediate assumptions), this occurs almost 30 years sooner—2035—and by 2075 Medicare consumes over 8 percent of GDP, compared with 5.3 percent under the old assumption. The difference clearly demonstrates the dramatic implications of a 1 percentage point increase in annual Medicare spending over time.

[1]Technical Review Panel on the Medicare Trustees Reports, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* (Dec. 2000). As the panel noted, for many years the Medicare projections have been based on an assumption that in the long run, average per-beneficiary costs would increase at about the same rate as program underlying funding sources. For HI, this meant that expenditures were assumed to increase at the same rate as average hourly earnings. For SMI, this meant that per-beneficiary costs were assumed to grow at the same rate as per-capita GDP.

[2]CBO, *The Long-Term Budget Outlook* (Oct. 2000).

[3]See *2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (March 2001) and *2001 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (March 2001).

Figure 2: Medicare Spending as a Share of GDP Under Old and New Assumptions



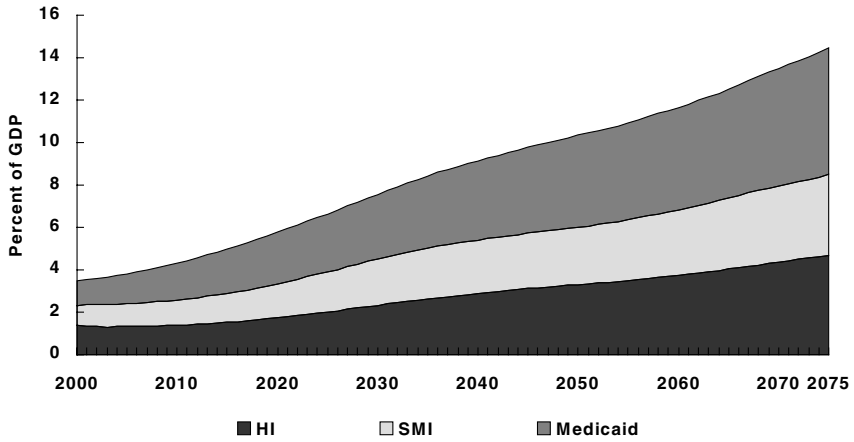
Note: Data are gross outlays as projected under the Trustees' intermediate assumptions.

Source: GAO analysis of data from the 2000 and 2001 HI and SMI Trustees Reports.

Figure 3 reinforces the need to look beyond the HI program. HI is only the first layer in this figure. The middle layer adds the SMI program, which is expected to grow faster than HI in the near future. By the end of the 75-year projection period, SMI will represent almost half of total estimated Medicare costs.

If federal Medicaid spending is also considered, an even more complete picture of the future health care entitlement burden emerges. Including Medicaid, federal health care costs will grow to 14.5 percent of GDP from today's 3.5 percent. Taken together, the two major government health programs—Medicare and Medicaid—represent an unsustainable burden on future generations. In addition, this figure reflects only the federal government's share—the burden of states' Medicaid matching costs on state budgets is another fiscal challenge. According to a recent National Governors Association statement, increased Medicaid spending has already made it difficult, if not impossible, for states to increase funding for other priorities.

Figure 3: Medicare and Medicaid Spending as a Share of GDP



Notes:

1. Medicare data are gross outlays as projected under the Trustees' 2001 intermediate assumptions.

2. Federal Medicaid data based on CBO's October 2000 long-term budget outlook.

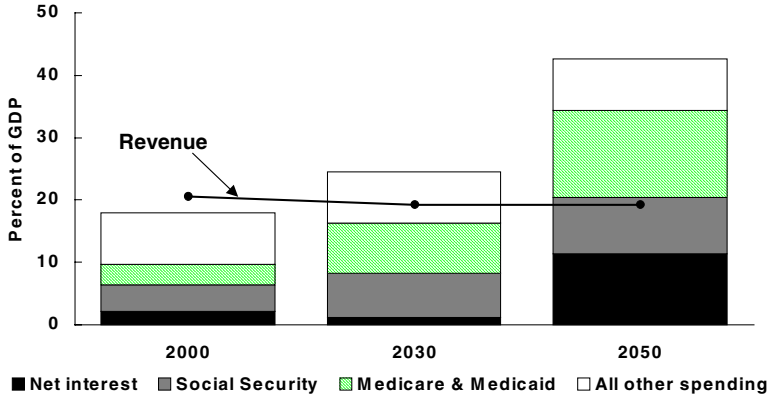
Source: GAO analysis of data from the Congressional Budget Office and the March 2001 HI and SMI Trustees Reports.

When viewed from the perspective of the federal budget and the economy, the growth in health care spending will become increasingly unsustainable over the longer term.[4] Our message remains the same as in my earlier appearances before this Committee: to move into the future with no changes in federal health and retirement programs is to envision a very different role for the federal government in the future. Assuming, for example, that Congress and the President adhere to the often-stated goal of saving the Social Security surpluses, our long-term simulations show a world by 2030 in which Social Security, Medicare, and Medicaid absorb

[4]See *Long-Term Budget Issues: Moving from Balancing the Budget to Balancing Fiscal Risk* (GAO-01-385T, Feb. 6, 2001). Given CBO's October 2000 long-term health cost estimates and the Medicare technical panel's higher long-term cost growth recommendation, we incorporated higher long-term health care cost growth consistent with the Medicare technical panel's recommendation into our January 2001 updates of our long-term simulations.

most of the available revenues within the federal budget. Under this scenario, these programs would require more than three-quarters of total federal revenue even without adding a prescription drug benefit.[5] (See fig. 4.)

Figure 4: Composition of Federal Spending as a Share of GDP Under the "Save the Social Security Surpluses" Simulation



Notes:

1. Revenue as a share of GDP declines from its 2000 level of 20.6 percent to 19.3 percent due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.

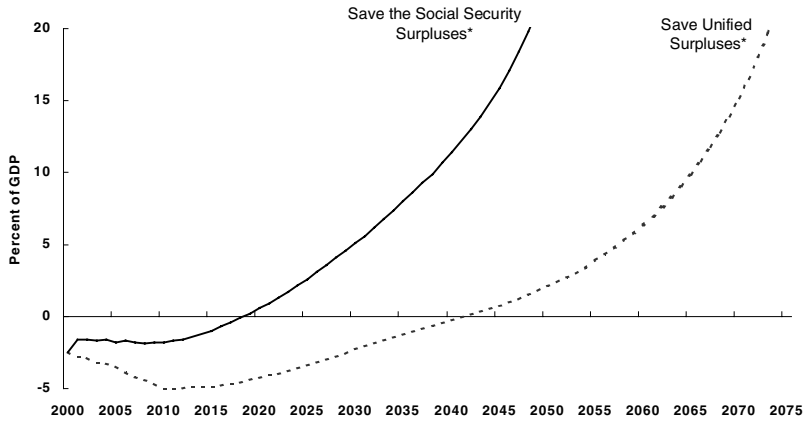
2. The Save the Social Security Surpluses simulation can be run only through 2055 due to the elimination of the nation's capital stock.

Source: GAO's January 2001 analysis.

Little room would be left for other federal spending priorities such as national defense, education, and law enforcement. Absent changes in the structure of Medicare and Social Security, sometime during the 2040s government would do nothing but mail checks to the elderly and their health care providers. Accordingly, substantive reform of the Medicare and Social Security programs remains critical to recapturing our future fiscal flexibility. As our long-term budget simulations show, this is true even if the entire projected surplus is saved. (See fig. 5.)

[5]The "Save the Social Security Surplus" simulation assumes that tax cuts and/or spending increases equal to the size of the on-budget surplus are enacted.

Figure 5: Unified Deficits as a Share of GDP Under Alternative Policy Simulations



*Data end when deficits reach 20 percent of GDP.

Source: GAO's January 2001 analysis.

Higher cost estimates are not the only reason why early action to address the daunting challenges of Medicare is critical. First, ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. The high projected growth of Medicare in the coming years means that the earlier reform begins, the greater the savings will be as a result of the effects of compounding.

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our nation's future capacity to afford paying benefits in the face of an aging society. Decisions on how we use today's surpluses can have wide-ranging impacts on our ability to afford tomorrow's commitments. As I have testified before, you can think of the budget choices you face as a portfolio of fiscal options balancing today's unmet needs with tomorrow's fiscal challenges. At the one end—with the lowest risk to the long-range fiscal position—is reducing publicly held debt. At the other end—offering the greatest risk—is increasing entitlement spending without fundamental program reform.

Reducing publicly held debt helps lift future fiscal burdens by freeing up budgetary resources encumbered for interest payments, which currently

represent more than 12 cents of every federal dollar spent, and by enhancing the pool of economic resources available for private investment and long-term economic growth. This is particularly crucial in view of the known fiscal pressures that will begin bearing down on future budgets in about 10 years as the baby boomers start to retire. However, as noted above, debt reduction is not enough. Our long-term simulations illustrate that, absent entitlement reform, even saving all projected unified surpluses will ultimately be insufficient to prevent the return of large persistent deficits.

Benefit Expansions Will Need to Be Accompanied by Meaningful Reform

Despite common agreement that, without reform, future program costs will consume growing shares of the federal budget, there is also a mounting consensus that Medicare's benefit package should be expanded to cover prescription drugs, which will add billions to the program's cost. Thus, to contain spending while revamping benefits, the Congress is considering proposals to fundamentally reform Medicare. Our work on the nuts and bolts of the Medicare program provides, I believe, some considerations that are relevant to your discussion regarding the potential addition of a prescription drug benefit, various Medicare reform options based on competition, effective implementation and refinement of new policies, and improving program management. I make these observations ever mindful of the need to ensure the program's sustainability for the longer term.

Adding a Fiscally Responsible Prescription Drug Benefit Will Entail Multiple Trade-Offs

Among the major policy challenges facing the Congress today is how to reconcile Medicare's unsustainable long-range financial condition with the growing demand for an expensive new benefit—namely, coverage for prescription drugs. It is a given that prescription drugs play a far greater role in health care now than when Medicare was created. Today, Medicare beneficiaries tend to need and use more drugs than other Americans. However, because adding a benefit of such potential magnitude could further erode the program's already unstable financial condition, we face difficult choices about design and implementation options that will have a significant impact on beneficiaries, the program, and the marketplace.

Let's examine the current status regarding Medicare beneficiaries and drug coverage. About a third of Medicare beneficiaries have no coverage for prescription drugs. Some beneficiaries with the lowest incomes receive coverage through Medicaid. Some beneficiaries receive drug coverage through former employers, some can join Medicare+Choice plans that offer drug benefits, and some have supplemental Medigap coverage that pays for drugs. However, significant gaps remain. For example,

Medicare+Choice plans offering drug benefits are not available everywhere and generally do not provide catastrophic coverage. Medigap plans are expensive and have caps that significantly constrain the protection they offer. Thus, beneficiaries with modest incomes and high drug expenditures are most vulnerable to these coverage gaps.

Overall, the nation's spending on prescription drugs has been increasing about twice as fast as spending on other health care services, and it is expected to keep growing. Recent estimates show that national per-person spending for prescription drugs will increase at an average annual rate exceeding 10 percent until at least 2010. As the cost of drug coverage has been increasing, employers and Medicare+Choice plans have been cutting back on drug benefits by raising enrollees' cost-sharing, charging higher copayments for more expensive drugs, or eliminating the benefit altogether.

It is not news that adding a prescription drug benefit to Medicare will be costly. However, the cost consequences of a Medicare drug benefit will depend on choices made about its design—including the benefit's scope and financing mechanism. The details of its implementation will also have a significant impact on beneficiaries, program spending, and the pharmaceutical market. Experience suggests that some combination of enhanced access to discounted prices, targeted subsidies, and measures to make beneficiaries aware of costs may be needed. Any option would need to balance concerns about Medicare sustainability with the need to address what will likely be a growing hardship for beneficiaries in obtaining prescription drugs.

Reform Options Based on Competition Offer Advantages but Contain Limitations

As you consider the options to add a drug benefit, fiscal prudence argues for balancing this action with the adoption of meaningful Medicare spending reforms. Before the 107th Congress are two leading proposals, popularly known as Breaux-Frist I and Breaux-Frist II. Both proposals are based on a model in which a competitive process determines the amount that the government and beneficiaries pay to participating health plans. Currently, Medicare follows a complex formula to set payment rates for Medicare+Choice plans, and plans compete primarily on the richness of their benefit packages. Medicare permits plans to earn a reasonable profit, equal to the amount they can earn from a commercial contract. Efficient plans that keep costs below the fixed payment amount can use the "savings" to enhance their benefit packages, thus attracting additional members and gaining market share. Under this arrangement, competition

among Medicare plans may produce advantages for beneficiaries, but the government reaps no savings.[6, 7]

In contrast, the competitive premium approach of both Breaux-Frist proposals offers certain advantages. Instead of having the government administratively set a payment amount and letting plans decide—subject to some minimum requirements—the benefits they will offer, plans would set their own premiums and offer at least a required minimum Medicare benefit package. Under both proposals, beneficiaries would generally pay a portion of the premium and Medicare would pay the rest. Plans operating at lower cost could reduce premiums, attract beneficiaries, and increase market share. Beneficiaries who joined these plans would enjoy lower out-of-pocket expenses. Unlike today's Medicare+Choice program, the premium support approach provides the potential for taxpayers to benefit from the competitive forces. As beneficiaries migrated to lower-cost plans, the average government payment would fall.

A key difference between the two Breaux-Frist proposals is in how the program's contribution is determined. Under Breaux-Frist I, traditional Medicare would, like the other plans, have to set a premium price. The amount of the program contribution would be based on the average of the traditional plan's premium price and the prices set by the other plans. Under Breaux-Frist II, the program contribution would be based on the traditional plan's premium price alone. Under either version, Medicare costs would be more transparent: beneficiaries could better see what they and the government were paying for in connection with health care expenditures. More importantly, both beneficiaries and the government would share in the savings if plans lower premiums to gain market share.

Experience with the Medicare+Choice program reminds us that competition in Medicare has its limits. First, not all geographic areas are able to support multiple health plans. Medicare health plans historically have had difficulty operating efficiently in rural areas because of a sparseness of both beneficiaries and providers. In 2000, 21 percent of rural beneficiaries had access to a Medicare+Choice plan, compared to 97 percent of urban beneficiaries. Second, separating winners from losers is a

[6]Beginning in 2003, plans can use savings to reduce beneficiaries' Part B premiums. Plans choosing to do so must share a portion of these savings with the program.

[7]In fact, the government has been losing money on the Medicare+Choice program. Medicare pays more, on average, for beneficiaries enrolled in managed care plans than if these individuals had remained in traditional Medicare. See *Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending* (GAO/HEHS-00-161, Aug. 23, 2000).

basic function of competition. Thus, under a competitive premium approach, not all plans would thrive, requiring that provisions be made to protect beneficiaries enrolled in less successful plans.

Effective Implementation Requires Capacity to Assess and Refine New Policies

The fundamental nature of proposed Medicare reforms, such as adding a drug benefit or reshaping the program's design, makes monitoring the effects of these changes a necessary responsibility. Today, however, major difficulties exist in measuring the effects of Medicare policies in a comprehensive and timely manner, making it difficult to assess the appropriateness of both program expenditures and provision of services.

Although Medicare is the nation's largest third-party payer, some of its vital information systems are decades old and operate on software no longer commonly used. These systems house a wealth of health and payment data but lack the flexibility to generate the kind of prompt and reliable reports that other large payers use to ensure health care quality and efficiency. This dearth of timely, accurate, and useful information hinders effective policymaking. This shortcoming is particularly significant in a program where small rate changes developed from faulty estimates can mean billions of dollars in overpayments or underpayments.

Our work on BBA payment reforms shows the importance of data-driven analyses in determining the impact of policy changes. Providers affected by BBA-mandated lower rates, lower rate increases, or altogether new payment systems blamed the BBA for their financial difficulties and pressured the Congress to undo some of the act's payment reforms. The Congress responded by making adjustments in subsequent legislation, but the affected providers argue that more changes are needed and call for higher payments on the basis of anecdotal evidence. Medicare analysts were ill-equipped to address these concerns through objective analysis because the necessary program data were not readily available. Our own reviews of BBA provisions and their impact showed that payments generally were adequate to cover providers' Medicare costs and ensure beneficiary access, although we identified areas where refinements would improve the appropriateness of rates to individual providers.

The lesson is that better information, promptly generated, can help policymakers understand the budgetary impact of policy changes and distinguish between desirable and undesirable consequences. Such information could, for example, reveal whether across-the-board rate increases are warranted or will result in overly generous payments for some and inadequate payments for others. Based on good data, refinements can help ensure that payments are not only adequate in the

aggregate but also fairly targeted to protect individual beneficiaries and providers. The BBA experience underscores the need to rely on hard data and objective analyses rather than assertions and anecdotes. It also argues for the Congress to ensure that adequate resources are secured for efforts underway to modernize Medicare's information systems and conduct needed research and analyses.

Effective Leadership and Sufficient Capacity Are Critical to Success of Medicare Reform

The extraordinary challenge of developing and implementing Medicare reforms should not be underestimated. Our look at health care spending projections shows that, with respect to Medicare reform, "getting it wrong" will have severe consequences. To get it right, effective program design will need to be coupled with competent program management. With that goal in mind, questions have been raised about the capacity of the Health Care Financing Administration (HCFA)—Medicare's current steward—to administer the Medicare program effectively. Our reviews of Medicare program activities confirm the legitimacy of these concerns and suggest that changes may be necessary to HCFA's focus, structure, resources, and operations.

Several proposals have been made to address HCFA management shortcomings. One approach is to create an entity that would administer Medicare without any non-Medicare responsibilities. The rationale for this view is that HCFA's other responsibilities—administering Medicaid, the State Children's Health Insurance Program, and other oversight, enforcement, and credentialing programs—constitute a separate full-time job. In the meantime, effective Medicare management requires monitoring the claims payment and review activities of more than 50 contractors; setting thousands of payment rates for the various providers of Medicare-covered services; and administering consumer information and beneficiary protection activities for the traditional fee-for-service component and Medicare+Choice plans. Alternative approaches would divide the administration of Medicare's components between HCFA and an entirely new entity. The intention would be to eliminate a conflict of interest that some perceive exists in having the same agency manage both the traditional fee-for-service and the managed care components.

More details would be necessary before the Congress could consider the merits of one approach over another. Creating a new agency allows for a fresh start, eliminating the need to reengineer established practices. The downside is that it typically takes years before a new agency acquires the personnel and infrastructure to become fully effective. In addition, it is questionable whether the perceived advantages of dividing Medicare's

administration would outweigh the inefficiencies that could result from duplication or coordination difficulties.

Closely allied with the issue of agency restructuring is the question of agency leadership. Frequent changes in HCFA leadership make it difficult for the agency to develop and implement a consistent long-term vision. The maximum term of a HCFA administrator is, as a practical matter, only as long as that of the President who appointed him or her. Historically, their terms have been much shorter. In the 24 years since HCFA's inception, there have been 20 administrators or acting administrators, whose tenure has been, on average, little more than 1 year. These short tenures have not been conducive to carrying out whatever strategic plans or innovations an individual may have developed for administering Medicare efficiently and effectively. Other federal agencies offer a precedent for an administrator's tenure to span presidential administrations. For example, the FBI director's term is 10 years and the Social Security Administrator's term is 6 years. A benefit of similarly lengthening the HCFA administrator's tenure would be to better insulate the program from short-term political pressures.

No matter how well-conceived or how well-led, however, no agency can function effectively without adequate resources and appropriate accountability mechanisms. Over the years, HCFA's administrative dollars have been stretched thinner as the agency's mission has grown. Adequate resources are vital to support the kind of oversight and stewardship activities that Americans have come to count on—inspection of nursing homes and laboratories, certification of Medicare providers, collection and analysis of critical health care data, to name a few. We and other health policy experts, including several former HCFA administrators, contend that too great a mismatch between the agency's administrative capacity and its designated mandate will leave HCFA unprepared to handle Medicare reforms and future population growth. In 1999, Medicare's operating expenses represented less than 2 percent of the program's benefit outlays. Although private insurers incur other costs, such as those for advertising, and seek to earn a profit, they would not attempt to manage such a large and complex program with so comparatively small an administrative budget.

It is not yet clear whether a successfully administered Medicare program requires reengineering HCFA, creating an entirely new agency, or some combination of the two options. What is clear, however, is that the program's effective governance rests on finding a balance between flexibility and accountability—that is, granting an entity adequate flexibility to act prudently and ensuring that the entity can be held

accountable for its results-based decisions and their implementation. Moreover, because Medicare's future will play such a significant role in the future of the American economy, we cannot afford to settle for anything less than a world-class organization to run the program. However, achieving such a goal will require a clear recognition of the fundamental importance of efficient and effective day-to-day operations.

Conclusions

In determining how to reform the Medicare program, much is at stake—not only the future of Medicare itself but also assuring the nation's future fiscal flexibility to pursue other important national goals and programs. I feel that the greatest risk lies in doing nothing to improve the Medicare program's long-term sustainability. It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Engaging in a comprehensive effort to reform the Medicare program and put it 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. While not ignoring today's needs and demands, we should remember that surpluses can also serve as an occasion to promote the transition to a more sustainable future for our children and grandchildren.

Updating Medicare's benefit package may be a necessary part of any realistic reform program. Such changes, however, need to be considered in the context of Medicare's long-term fiscal outlook and the need to make changes in ways that will promote the program's longer-term sustainability. We must remember that benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. The BBA experience reminds us about the difficulty of undertaking reform.

Specifically, we must acknowledge that adding prescription drug coverage to the Medicare program would have a substantial impact on program costs. At the same time, many believe it is needed to ensure the financial well-being and health of many of its beneficiaries. The challenge will be in designing and implementing drug coverage that will minimize the financial implications for Medicare while maximizing the positive effect of such coverage on Medicare beneficiaries. Most importantly, any substantial benefit reform should be coupled with other meaningful program reforms that will help to ensure the long-term sustainability of the program. In the end, the Congress should consider adopting a Hippocratic oath for Medicare reform proposals—namely, "Don't make the long-term outlook worse." Ultimately, we will need to engage in a much more fundamental

health care reform debate to differentiate wants, which are virtually unlimited, from needs, which should be defined and addressed, and overall affordability, of which there is a limit.

We at GAO look forward to continuing to work with this Committee and the Congress in addressing this and other important issues facing our nation. In doing so, we will be true to our core values of accountability, integrity, and reliability.

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

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon, Health Care Issues, at (202) 512-7114 or Paul L. Posner, Federal Budget and Intergovernmental Relations, at (202) 512-9573. Other individuals who made key contributions include Linda F. Baker, James C. Cosgrove, Paul Cotton, Hannah F. Fein, James R. McTigue, and Melissa Wolf.

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