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

G A O
Accountability * Integrity * Reliability

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.

[1]Under 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.

- 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—

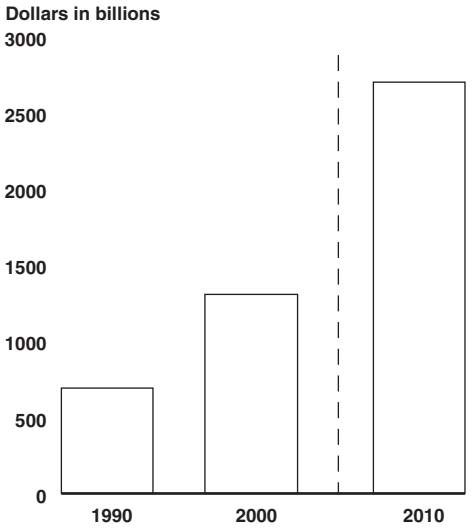
that is, a comprehensive set of criteria—for consideration by the Congress, to help policymakers evaluate proposed health care reforms.

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

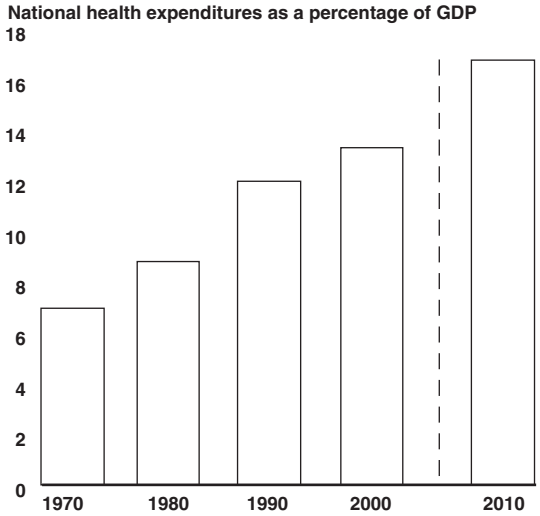


Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group.

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

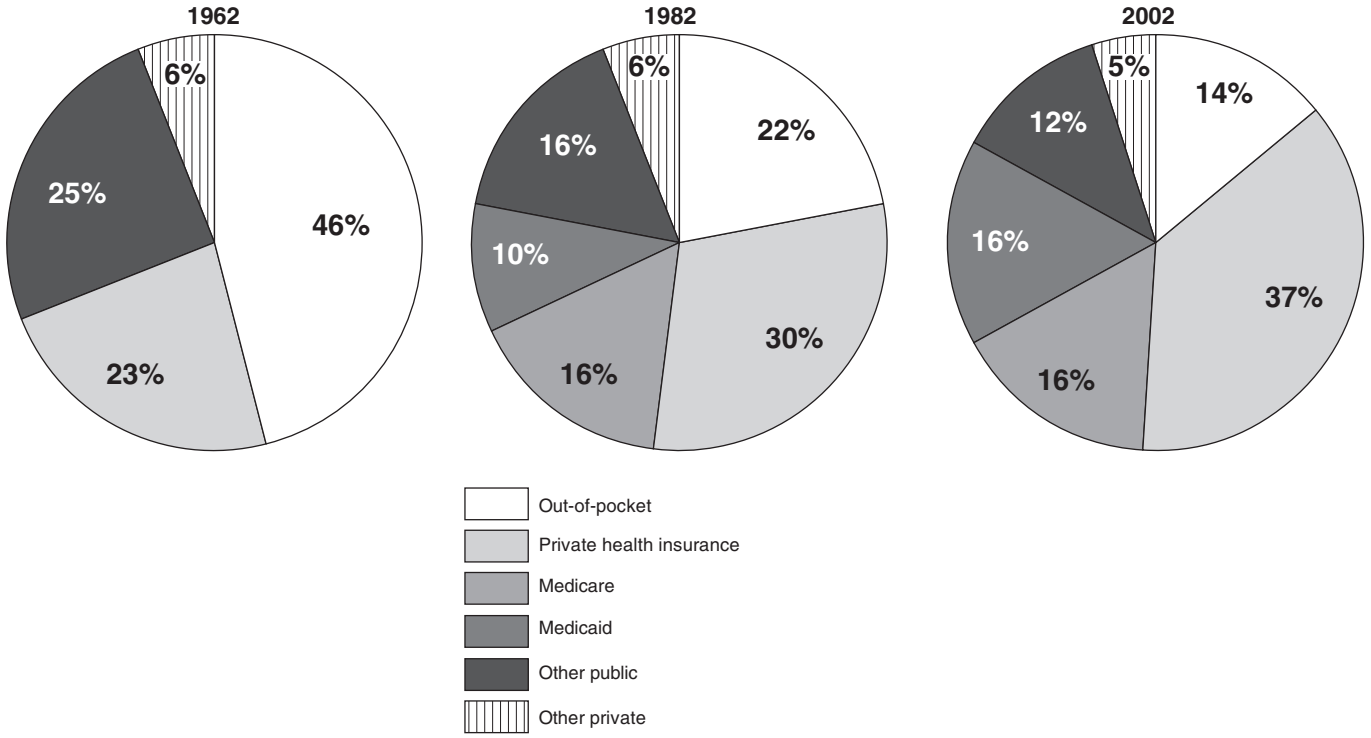


Sources: CMS, Office of the Actuary, National Health Statistics Group and U.S. Department of Commerce, Bureau of Economic Analysis.

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.

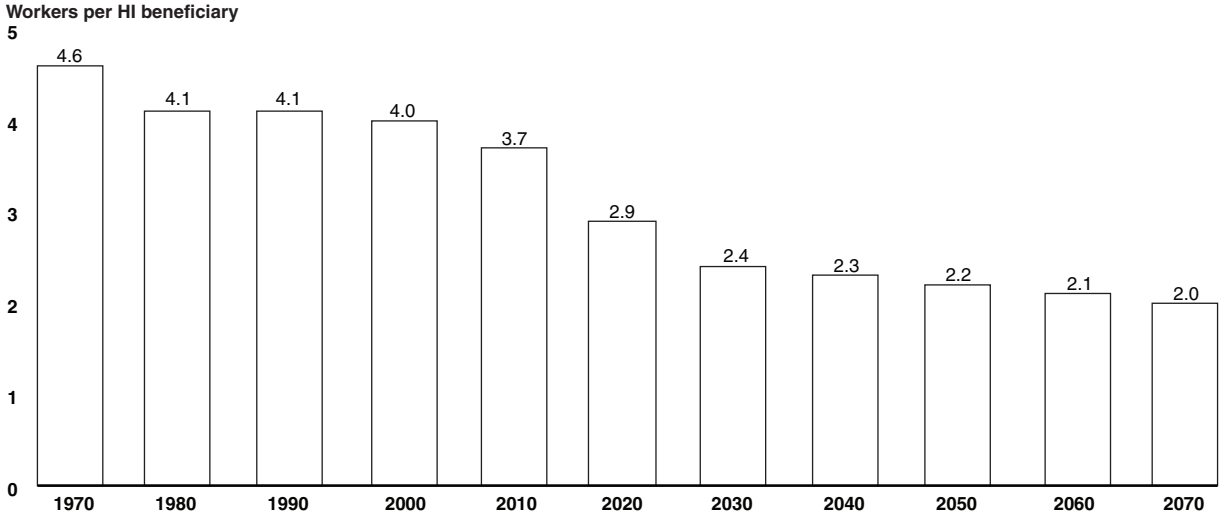
Demographic Trends And Expected Rise in Health Care Costs Drive Medicare's Long-Term Financing Problem

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.)

[2]Another 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.

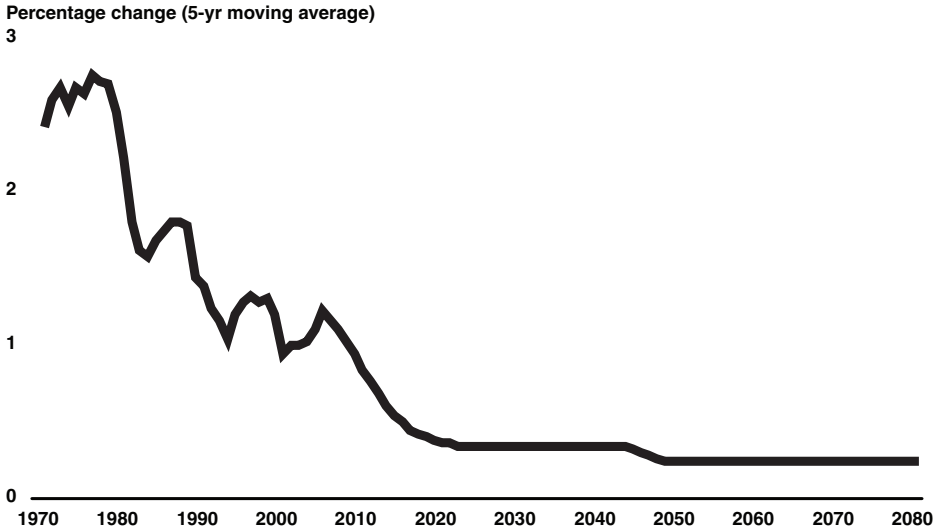
Note: Projections based on the intermediate assumptions of *The 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.*

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



Source: Social Security Administration, Office of the Chief Actuary, and GAO.

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.

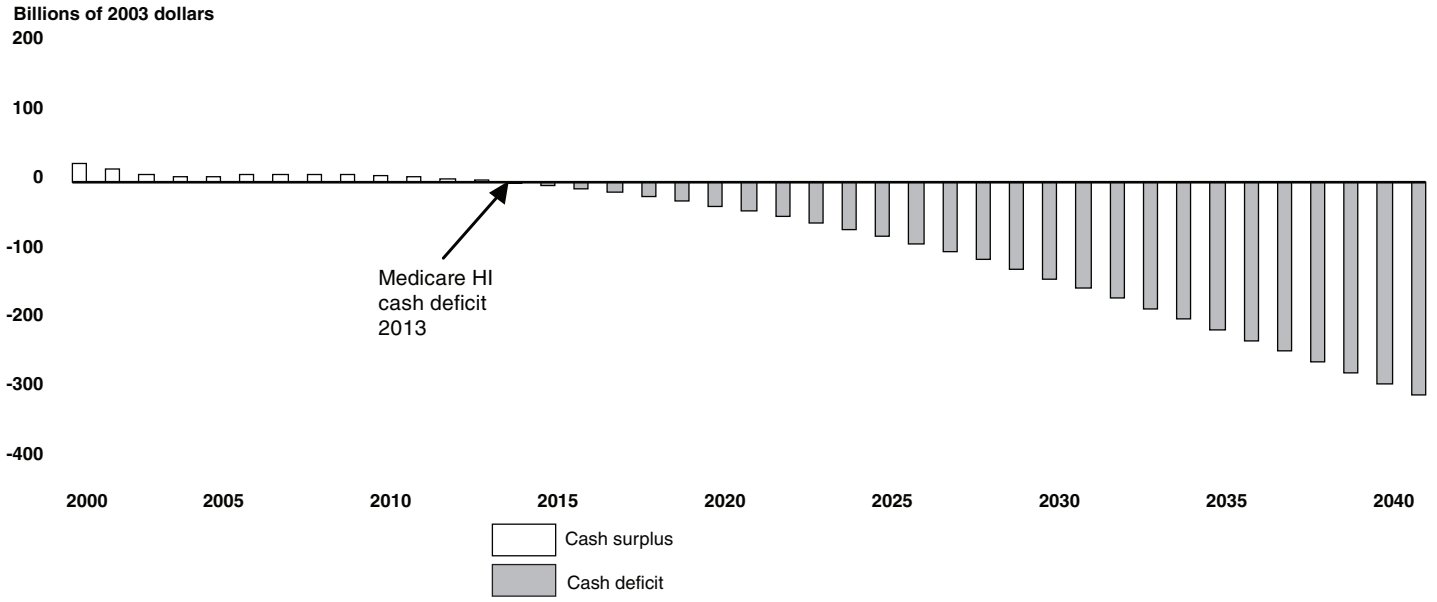
The demographic trends I have described will affect both Medicare and Social Security, but Medicare presents a much greater, more complex, and more urgent challenge. Unlike Social Security, Medicare spending growth rates reflect not only a burgeoning beneficiary population, but also the escalation of 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*.

[3]Under 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

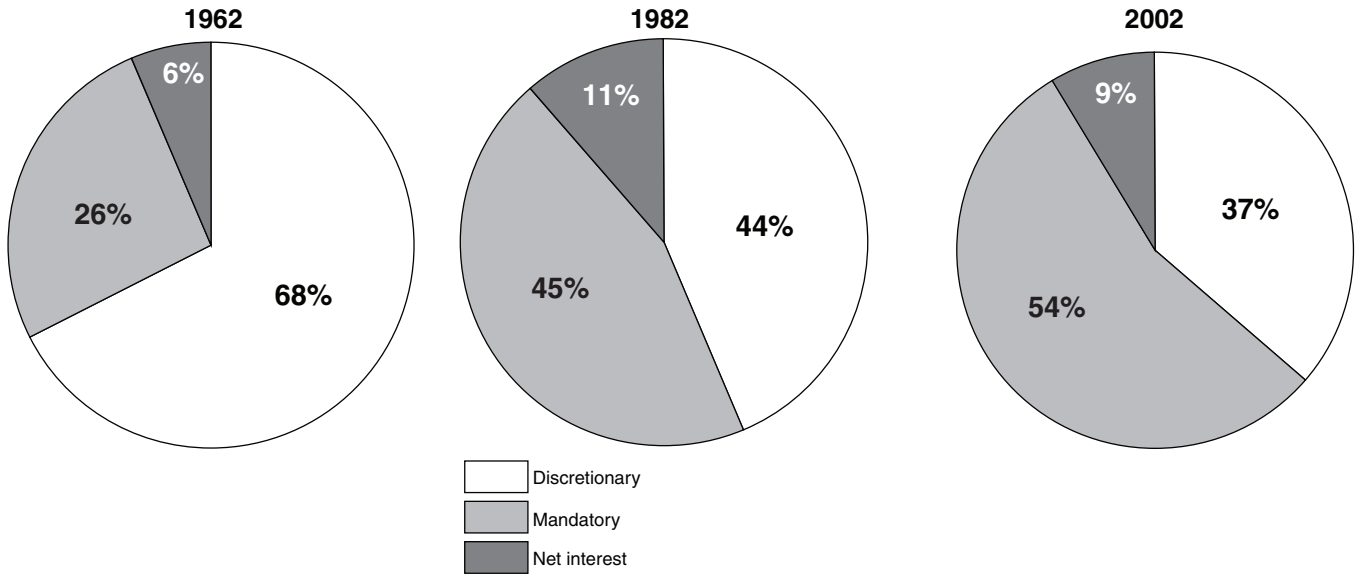
future total program spending, new measures of Medicare's sustainability are needed. As program changes are made, a continued need will exist for measures of program sustainability that can signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided 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



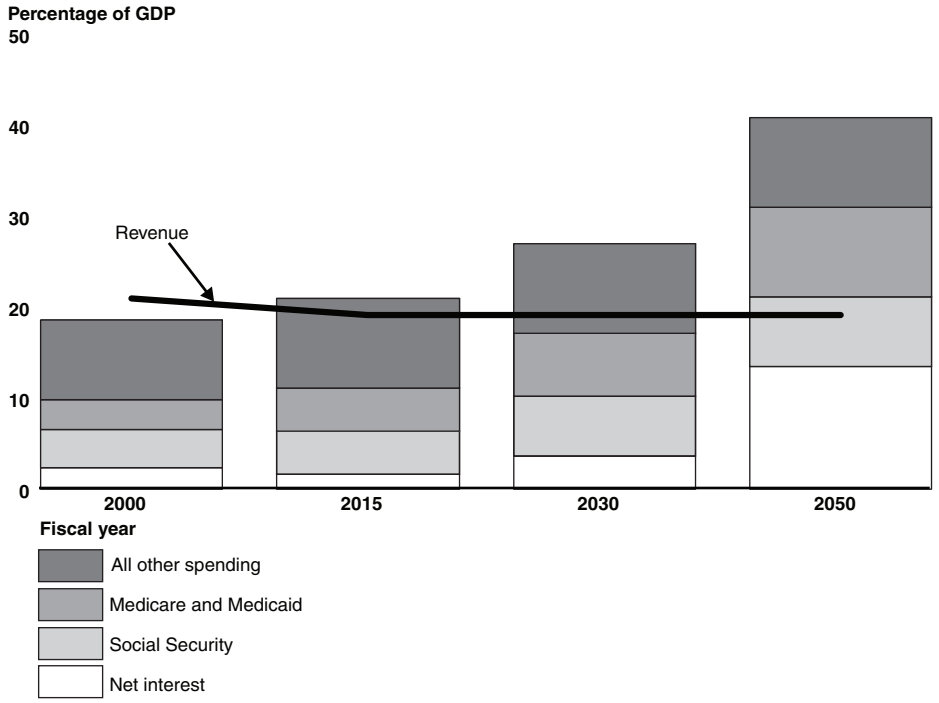
Source: *Budget of the United States Government: Fiscal Year 2004, Office of Management and Budget.*

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.

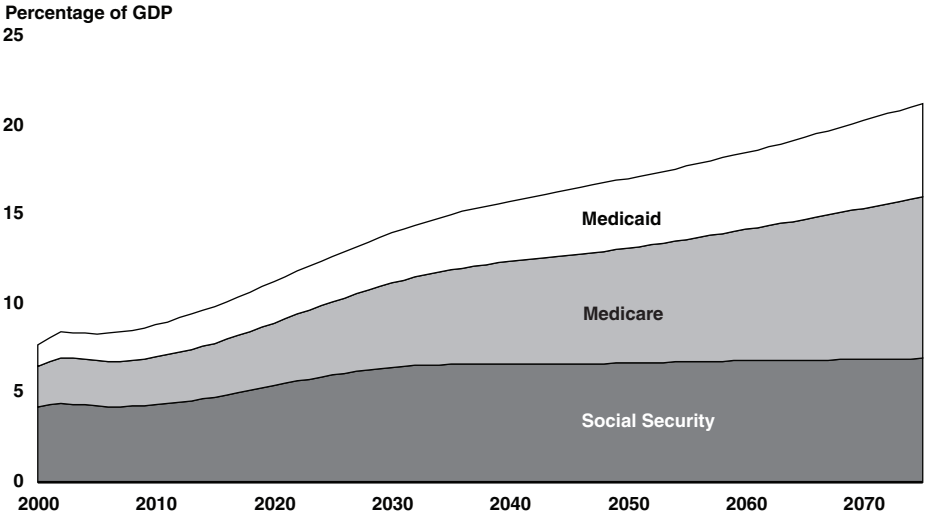
Indeed, long-term budgetary flexibility is about more than Social Security and Medicare. While these programs dominate the long-term outlook, they are not the only federal programs or activities that bind the future. The federal government undertakes a wide range of programs, responsibilities, and activities 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.

[5]U.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

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

[7]In 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.[8] 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

[8]This 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

[9]Mary 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_c.php?ID=http://www.healthaffairs.org/Library/v21n2/s4.pdf (downloaded Mar. 19, 2003).

[10]The 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

[11]Beginning 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.

[12]See 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.

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.

Difficulties in Setting Payment Rates

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

[13]See 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 McTigue, Yorick F. Uzes, and Melissa Wolf.

Related GAO Products

Major Management Challenges and Program Risks: Department of Health and Human Services. GAO-03-101. Washington D.C.: January 2003.

Fiscal Exposures: Improving the Budgetary Focus on Long-Term Costs and Uncertainties. GAO-03-213. Washington, D.C.: January 24, 2003.

Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities. GAO-03-183. Washington, D.C.: December 31, 2002.

Medicare Home Health Care: Payments to Home Health Agencies Are Considerably Higher than Costs. GAO-02-663. Washington, D.C.: May 6, 2002.

Medicare: Financial Outlook Poses Challenges for Sustaining Program and Adding Drug Coverage. GAO-02-643T. Washington, D.C.: April 17, 2002.

Medigap: Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives. GAO-02-533T. Washington, D.C.: March 14, 2002.

Medicare: New Spending Estimates Underscore Need for Reform. GAO-01-1010T. Washington, D.C.: July 25, 2001.

Medicare: Cost-Sharing Policies Problematic for Beneficiaries and Program. GAO-01-713T. Washington, D.C.: May 9, 2001.

Medicare: Higher Expected Spending and Call for New Benefit Underscore Need for Meaningful Reform. GAO-01-539T, Washington, D.C.: March 22, 2001.

Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings. GAO/HEHS-00-183. Washington, D.C.: September 7, 2000.

Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending. GAO/HEHS-00-161. Washington, D.C.: August 23, 2000.