

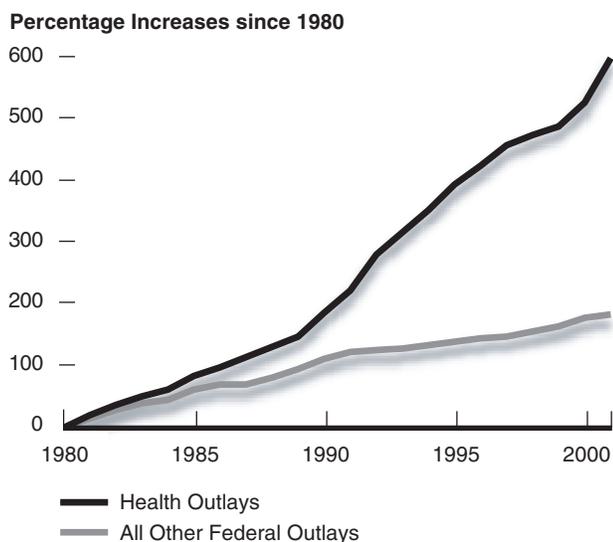


Strategic Objective:

The Health Needs of an Aging and Diverse Population

Issue: Health care has been one of the most rapidly rising elements of federal spending, growing at an average annual rate twice that of the rest of the federal budget over the last 10 years (see fig. 1.1). Expenditures on health-related programs are now one of the largest components of federal spending, totaling an estimated \$433 billion in fiscal year 2001, or about 23 percent of all federal spending that year. Health care also accounts for significant federal tax expenditures, with \$92 billion in forgone revenues projected for 2002 because of employer contributions to medical care and medical insurance. The cost pressures of serving a growing population are compounded by scientific advances in medical treatments, which can blur the lines between needs and wants and make it difficult to reasonably assess what society can afford.

Figure 1.1: Growth of Federal Health Expenditures, 1980 through 2001



Note: The 2001 number is an estimate.

Source: Office of Management and Budget.

Of particular concern is the growth in Medicare expenditures, which are estimated to total about \$264 billion in 2002. Without changes, Medicare is expected to nearly double its share of the economy by 2030, crowding out other spending and economic activity of value. Indeed, one part of Medicare, the Medicare Hospital Insurance Trust Fund, is projected to begin running a deficit in 2016 and to be depleted by 2029. Also of concern are issues of (1) modernizing Medicare's management structure, payment policies and methodologies, and benefits package, and (2) reducing Medicare's administrative burden on providers. Moreover, because of its size and complexity, Medicare is inherently difficult to manage. About 50 insurance companies process and pay approximately 900 million claims annually to nearly 1 million health care providers. Consequently, the program is a target for fraud, waste, and abuse, and effective oversight is critical to protecting program dollars and promoting efficient program operations.

A strong private insurance market that provides access to affordable employer-based or individually purchased health coverage can reduce the demand for government-funded insurance programs. However, despite a strong economy for much of the last decade, the number of Americans without health insurance remains high. Although the introduction of competitive principles to health care helped to contain medical care cost increases for many years, costs are increasing significantly once again. These cost increases, in concert with a recent downturn in the economy, have important implications for the availability of employer-sponsored health insurance and for federal health care programs and outlays. Moreover, the public is concerned about the quality of care, consumer protection mechanisms, and the availability of information to allow purchasers to make informed insurance choices.

The government also must address pressing issues in its own system of hospitals and clinics. The Department of Veterans Affairs (VA)—one of the nation's largest health care systems—spends about \$21 billion a year to provide health care to approximately 4.3 million veteran patients. The Department of Defense's (DOD) health care system spends about \$25 billion annually to support health care to about 8.2 million eligible beneficiaries. Yet, much of VA's physical infrastructure is obsolete and burdened with excess capacity, and the size and other requirements for DOD facilities are currently at issue. Pressure is also mounting to integrate aspects of the two systems to increase their efficiency and effectiveness.

The efficiency and effectiveness of the government's public health programs are other areas of concern, including those administered by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. These programs support and conduct research; provide grants to states for public health programs, such as maternal and child health services and AIDS prevention and treatment; and conduct regulatory oversight of the United States' new drug and medical device research. Questions have been raised about the government's ability to ensure the necessary protection of patients in research as well as to safeguard the public in the review of new pharmaceuticals, medical devices, and new food products. Additionally, the changing nature of public health threats domestically and internationally, such as antimicrobial resistance, HIV infection, and other emerging infectious diseases, poses significant challenges for the government. As diseases such as HIV and tuberculosis have become pandemics, the effectiveness of international health programs to prevent and adequately treat populations in developing countries is a growing concern. Government's ability to help surmount shortages of certain prescription drugs and vaccines is a worldwide concern as well.

Since September 11 and the first reports of anthrax in Florida, New York, and Washington, D.C., the public health infrastructure has experienced additional strain in responding to community demand for public health services. This has heightened concern about the adequacy of trained personnel, laboratory capacity, disease surveillance systems, and coordinated communication systems among state and local emer-

gency responders. Greater attention has since been given to state and local communities' capacity to develop coordinated plans for dealing with a potential biological attack and to develop emergency response systems linking hospitals, emergency rooms, health personnel, and fire and police efforts to respond to any form of terrorism.

Finally, the baby-boom generation will undoubtedly place increasing pressure on the federal/state Medicaid program to help pay for nursing home and other community-based forms of long-term care services. Meeting an increasing demand for such services within the available funding will pose significant challenges for federal and state decision makers, with important implications for the services offered by each state. At the other end of the population spectrum are millions of uninsured children whose families have no health insurance. Medicaid and the State Children's Health Insurance Program help cover the health insurance costs of these low-income Americans and are often viewed as established programs that may be expanded to help reduce the number of the uninsured. However, the recent flux in the managed care market, which states increasingly rely on to deliver services, may hamper states in their ability to attract and retain managed care plans and providers and to ensure beneficiary access to needed, cost-effective services. Moreover, accounting for and overseeing these two programs represents a formidable challenge for the federal government because of the variation in state policies, procedures, and delivery systems.

Performance Goals: To support efforts by the Congress and the federal government to address these issues, GAO will

- evaluate Medicare reform, financing, and operations;
- assess trends and issues in private health insurance coverage;
- assess actions and options for improving VA's and DOD's health care services;
- evaluate the effectiveness of federal programs to promote and protect the public health;
- evaluate the effectiveness of federal programs to improve the nation's preparedness for the public health and medical consequences of bioterrorism;

- evaluate federal and state program strategies for financing and overseeing chronic and long-term health care; and

- assess states' experiences in providing health insurance coverage for low-income populations.

Evaluate Medicare Reform, Financing, and Operations

Key Efforts

- ❑ Analyze the potential consequences of Medicare structural reforms
- ❑ Assess the effects of expanding managed care in Medicare
- ❑ Evaluate the Centers for Medicare and Medicaid Services' (CMS) management of Medicare, including its implementation of legislative reforms and its service to providers and beneficiaries
- ❑ Evaluate methodologies for setting fair reimbursement rates for Medicare providers
- ❑ Assess the effects of different payment rates on access to, and the quality of, health care services
- ❑ Evaluate CMS's safeguards and program controls over provider payments and beneficiary access and quality

Significance

Medicare now finances health care for about 40 million Americans, accounting for about one-eighth of all federal expenditures. Without changes, Medicare is expected to nearly double its share of the nation's economy by 2030, crowding out other government spending and economic activity. Medicare's Hospital Insurance Trust Fund is projected to begin running a cash deficit in 2016 and become insolvent by 2029. Payment systems and other policies have not always provided beneficiaries and providers with incentives to seek care in a cost-effective manner. While structural changes, such as managed care, were intended to introduce market competition to Medicare, with the goal of containing health care use and costs, their implementation and acceptance have been somewhat problematic. Other options to fundamentally reform Medicare have been proposed, such as modernizing the benefit package, restructuring beneficiary cost-sharing, and providing incentives for beneficiaries to make cost-effective choices among health plans. Medicare and other federal health programs also face the contentious task of setting rates, or calibrating payments to match the health care costs of patients. The government overpays when the rates are set too high relative to these costs, but if the rates are set too low, providers may try to avoid treating sicker patients who require extra care and services. Effectively managing the Medicare program, including safeguarding its integrity, remains a continuing challenge. Because Medicare pays out over \$220 billion annually and is responsible for financing health services delivered by hundreds of thousands of providers, it is an especially attractive target for fraud, waste, abuse, and, therefore, good management is critical.

Potential Outcomes that Could Result when GAO's Work Is Used

Better congressional understanding of Medicare reform proposals, including implications for the budget and for health care

More cost-effective Medicare managed care programs

Improvements in CMS's program management and implementation of legislated Medicare program changes

Medicare rate-setting methodologies that minimize federal costs and promote access to quality medical care

Reductions in improper payments to health care providers

Assess Trends and Issues in Private Health Insurance Coverage

Key Efforts

- ❑ Evaluate trends in, and distribution of, health insurance coverage
- ❑ Analyze trends in health insurance premium costs, including cost drivers, consequences, and employer and provider responses
- ❑ Analyze potential modifications to federal tax policies for their impact on the numbers of uninsured, costs of health care services, and implementation challenges for federal and state agencies
- ❑ Assess the impact of public and private efforts to achieve compliance with federal health insurance standards

Significance

Private employer-sponsored health insurance provides coverage for more than 175 million Americans; however, about 39 million Americans did not have health insurance in 2000. The tax code and the Employee Retirement Income Security Act of 1974 strongly influence the private health insurance market. Beginning with the Health Insurance Portability and Accountability Act of 1996, the Congress has established additional standards for private health insurance coverage. Furthermore, strong interactions exist between the private health insurance market and public health insurance programs, including Medicare and Medicaid, with financing innovations in the private or public sector often being adopted by the other sector. Efforts to contain costs or improve access in one sector may lead to unintended consequences for the other. In particular, the Federal Employees' Health Benefits Program, which provides health insurance to about 9 million federal employees, retirees, and dependents, has sometimes been considered a model for other large employers or public programs, but has also had to address issues of increasing costs and pressure for expanded benefits. These complex interrelations between federal policy and the private health insurance market greatly affect the affordability, availability, and quality of insurance coverage that most—but not all—Americans receive.

Potential Outcomes that Could Result when GAO's Work Is Used

More complete congressional understanding of trends in health insurance coverage, including changes in private health insurance coverage and the evolving health insurance market

Improved congressional understanding of how changes in health insurance premiums affect both the availability of private health insurance coverage as well as the cost and demand on public health insurance programs

Better congressional understanding of proposals to alter tax treatment of private health care insurance costs

Better congressional understanding of the impact of public and private efforts to achieve compliance with federal health insurance standards

Assess Actions and Options for Improving the Departments of Veterans Affairs and Defense's Health Care Services

Key Efforts

- ❑ Evaluate proposals to restructure or consolidate VA and DOD health care systems, including proposals on realigning medical education, research, unneeded physical infrastructure, and purchased care acquisition strategies
- ❑ Assess implications of expansions of military health benefits and VA eligibility reforms
- ❑ Assess vulnerability of VA and DOD systems to fraud, waste, and abuse
- ❑ Examine access and quality of care provided to veterans and military beneficiaries
- ❑ Assess VA's and DOD's efforts to provide care to populations with special needs
- ❑ Review implementation of VA and DOD resource allocation systems, and budget formulation and execution practices
- ❑ Review VA's role and preparedness to meet its mission of backing up DOD and assisting state and local authorities in responding to civilian disasters

Significance

The Department of Veterans Affairs (VA) and the Department of Defense (DOD) operate two of the largest health care systems in the world, together spending about \$46 billion a year for health care. Both systems face great challenges. For instance, VA's health care system historically focused on hospital care using high technology and medical specialization. It did not keep pace, however, with industry and societal changes, such as the restructuring of health care to improve delivery of ambulatory care and the evolving medical needs of an aging veteran population. Consequently, VA's large, aged infrastructure could be the biggest obstacle confronting the agency's ongoing transformation efforts, requiring VA to spend a sizeable portion of its health care budget to operate, maintain, and improve its facilities. In addition, one of VA's health care missions is to provide backup medical resources to the military health system and to support state and local authorities responding to domestic terrorist incidents and other major disasters. The increasing prominence of federal preparedness, as the nation strengthens its strategy for homeland security, and the potential reserve call-up of VA medical personnel emphasize the challenges VA now faces in playing a potentially expanding role in federal preparedness while continuing to meet its other health care missions. Similarly, DOD faces pressures to adapt its health care structure to changing military threats, a decreased force size, and an evolving health care marketplace, characterized by rising costs and increasing beneficiary concerns about access. In response to these longstanding issues, DOD established its nationwide managed care program, TRICARE, in the mid-1990s. However, beneficiary concerns have continued under TRICARE, as have concerns about efficiency and questions about TRICARE's cost-effectiveness. Such conditions have focused attention on the prospective need for military medical facilities, the coordination of peacetime care among them, and alternative approaches to delivering care.

Potential Outcomes that Could Result when GAO's Work Is Used

More effective and efficient organizational structures and service delivery

Improved congressional understanding of how potential changes affect costs, utilization of services, and retention

Reductions in the amount of unnecessary health care expenditures by VA and DOD

Assess Actions and Options for Improving the Departments of Veterans Affairs and Defense's Health Care Services (cont.)

Better understanding of factors that explain variations in quality, timeliness of care, and patient safety

Better assurance of quality and minimization of negative impacts of cost-saving measures on the health care provided to vulnerable groups

Improved budgeting and resource allocation systems that more adequately reflect workload and costs, and promote efficiency and optimization

Improved readiness and minimized impact from a reserve call-up on VA's ability to provide care

Evaluate the Effectiveness of Federal Programs to Promote and Protect the Public Health

Key Efforts

- ❑ Evaluate the ability of the federal public health agencies to detect and counter emerging threats to the nation's health
- ❑ Evaluate impediments and barriers to the adequate supply of prescription drugs and vaccines
- ❑ Assess the regulatory structure for ensuring the safety and efficacy of medical devices, drugs, blood products, and alternative medical therapies
- ❑ Evaluate federal efforts to regulate access to medical records
- ❑ Evaluate the effectiveness of programs to reduce the demand for illicit drugs

Significance

To promote and protect the health of the nation, the public health agencies pursue a broad range of activities that tangibly affect the well-being of every American. These include conducting public health surveillance on new and emerging infectious diseases, nationally and internationally; sponsoring and conducting biomedical research; evaluating the effectiveness and safety of pharmaceutical and medical devices; and funding medical treatment for substance abuse. About 90 percent of the National Institutes of Health's annual budget of \$20 billion goes to fund biomedical research, contributing to a dramatic increase in the number of available medical treatments. New technologies and therapies will further test the ability of the Food and Drug Administration (FDA) to ensure the safety and efficacy of foods and dietary supplements as well as new medical products while not unduly delaying the availability of new products to consumers. The AIDS epidemic persists in this country and around the world and poses continuing prevention and treatment challenges to public health agencies. Advances in computing technology have prompted concerns about the privacy of medical records, as the nation seeks to both protect the privacy of individuals and facilitate research that may lead to substantial improvements in medical care. The changing nature of public health threats—including shortages of prescription drugs and vaccines, and spread of microbial-resistant tuberculosis—requires effective surveillance and prompt action by the Centers for Disease Control and Prevention and other public health agencies at the international, federal, state, and local levels.

Potential Outcomes that Could Result when GAO's Work Is Used

Increased ability of federal public health agencies' efforts to counter emerging public health threats

Improved access to essential medications and vaccines

More effective and efficient determination of the safety and efficacy of medical products by FDA

More effective standards for protecting the confidentiality of medical records

More effective drug prevention and treatment programs

Evaluate the Effectiveness of Federal Programs to Improve the Nation's Preparedness for the Public Health and Medical Consequences of Bioterrorism

Key Efforts

- ❑ Evaluate the effectiveness of federal programs in ensuring the preparedness of state and local governments for the public health and medical consequences of a bioterrorist attack
- ❑ Evaluate the security of laboratory facilities that possess or transfer select agents and other pathogens that could pose risks for use in bioterrorism
- ❑ Evaluate identified needs and associated cost projections for federally funded efforts at state and local government levels to improve public health surveillance, training, communication systems, and laboratories for bioterrorism preparedness
- ❑ Evaluate problems associated with the acquisition of vaccine stockpiles for smallpox and anthrax
- ❑ Evaluate emergency response systems and local hospital capacity to treat and care for mass casualties

Significance

The use of anthrax as a weapon of terrorism has heightened concern over the public health threats posed by biological terrorism and raised worries that the nation is not adequately prepared to respond to bioterrorist attacks. To improve the nation's preparedness, federal agencies engage in a number of activities aimed at improving detection, treatment, and response and the Congress is considering substantial increases in funding for these programs. These activities include public health surveillance systems to identify disease outbreaks, development of technologies to more rapidly detect and diagnose infectious agents, and improved communication systems to facilitate sharing information on disease outbreaks. Federal funding, primarily through the National Institutes of Health, has recently been increased for the development of vaccines, antibiotics, and antivirals to treat diseases that could result from bioterrorism. The Department of Health and Human Services is also building a National Pharmaceutical Stockpile of essential drugs and equipment that could be deployed to the scene of an outbreak and has contracted for a stockpile of smallpox vaccine. Several federal agencies provide funding to state and local governments for response planning, offer training for emergency response, fund equipment purchases, and maintain response teams that can be deployed in the event of an attack. However, concerns remain that funding may not be directed to the areas of greatest need.

Potential Outcomes that Could Result when GAO's Work Is Used

More effective programs to assist state and local government preparedness efforts

Improved security and reduction of vulnerabilities for bioterrorism

More effective and efficient allocation of resources for addressing state and local governments' needs

Improved access to essential vaccines

Improved planning and policies at the local level to address and respond to mass casualty incidents

Evaluate Federal and State Program Strategies for Financing and Overseeing Chronic and Long-Term Health Care

Key Efforts

- ❑ Examine nursing homes' compliance with federal and state quality standards
- ❑ Review federal requirements and standards and their use to ensure quality care in community-based, long-term care settings, such as home health, assisted living facilities, and adult day care
- ❑ Analyze public and private payment sources and strategies that finance the continuum of long-term care, including integrated programs for elderly or disabled beneficiaries who are dually eligible for Medicare and Medicaid

Significance

The aging of the baby boomers, combined with medical advances that are contributing to longer life expectancies, will lead to a tremendous increase in the elderly population over the next three decades. In particular, there will be a substantial increase in the number of individuals 85 and older, many of whom will require long-term care services. Financing these services—within the context of evolving service needs and alternative settings for receiving long-term care services—will be a challenge for the baby boomers, their families, and federal and state governments. After private expenditures (including out-of-pocket spending and long-term care insurance), Medicaid is the largest payer for long-term care, covering at least some of the costs for two-thirds of nursing home residents. Many individuals become impoverished, and thus eligible for Medicaid, by “spending down” their assets. Taken together, Medicaid, Medicare, and other public programs contributed to more than three-fifths of the \$137 billion spent on nursing home and home health care in 2000. Private insurance (including long-term care insurance as well as services paid by traditional health insurance) accounted for about 11 percent, with the remainder paid by the elderly, the disabled, or their families. The long-term care expenditures for the elderly are disproportionately used to purchase nursing home care. There is growing emphasis, however, on delivering services in the community rather than in nursing homes and other institutional settings—not only to the younger disabled but also to elderly individuals. The highly vulnerable nature of the long-term care population underscores the importance of oversight to ensure that providers comply with federal and state quality standards.

Potential Outcomes that Could Result when GAO's Work Is Used

Improved quality of care in nursing homes

Improved public and private awareness of alternatives to traditional long-term care settings and the federal role in ensuring quality care

Better congressional understanding of options for financing the increasing costs of long-term care

Assess States' Experiences in Providing Health Insurance Coverage for Low-Income Populations

Key Efforts

- ❑ Review Medicaid and SCHIP enrollment efforts to ensure access to services
- ❑ Evaluate Medicaid and SCHIP access to services under different service-delivery systems and payment methodologies
- ❑ Evaluate federal oversight of states' implementation of Medicaid and SCHIP

Significance

Despite strong economic growth during the 1990s, the number of uninsured remains high at about 39 million. Many of the uninsured are poor children with working parents who are themselves uninsured. Two federal/state programs address the needs of uninsured low-income children and other categories of low-income individuals—Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid, a means-tested entitlement program, provides medical care for about 40 million low-income individuals and currently comprises close to a fifth of states' expenditures. SCHIP was created in 1997 to provide health insurance to uninsured children whose family's income was too high to qualify for Medicaid. Some states have also added family coverage under SCHIP, primarily by providing premium assistance to working families with access to employer-based health insurance. Overseeing and maintaining accountability for these two public programs can be challenging because of state variation in eligibility rules, benefits, and delivery systems. Changes due to federal welfare reform, states' transition to managed care delivery systems, and recent increases in the use of waivers from statutory provisions to enhance states' flexibility, have complicated the reporting and monitoring of the services provided. Moreover, the recent turmoil in the managed care market, particularly the contraction and consolidation of commercial managed care plans, is likely to affect both Medicaid and SCHIP programs, particularly those that rely on capitated managed care (that is, care funded by uniform per-person fees) as a primary method of offering services to eligible beneficiaries. Federal oversight must balance support of state flexibility in designing and implementing their programs with the need to ensure the appropriate use of federal funds to meet the statutory and regulatory requirements of both programs. The Medicaid program continues to be vulnerable to questionable financing practices in some states that have generated excessive federal payments without the states paying their fair share or without assurances that the payments are for covered Medicaid services. Identifying such practices, as well as overall monitoring of the efficiency and effectiveness of Medicaid and SCHIP programs, have often been hampered by imprecise data, overdue reporting, and inadequate federal review of states' efforts.

Potential Outcomes that Could Result when GAO's Work Is Used

Greater access to services for eligible beneficiaries

More efficient and effective delivery of services.

Improved accountability and oversight of federal/state health-financing programs serving low-income populations