CBO TESTIMONY

Statement of
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NOTICE

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Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss reforming Medicare for the long term. Growth in Medicare spending has slowed remarkably in 1998 and 1999, partly because of provisions of the Balanced Budget Act of 1997 (BBA). Nonetheless, without reform the program is expected to face mounting pressures in coming years arising from rapid growth in the number of eligible people and increases in the cost of care per patient.

PROJECTIONS OF MEDICARE COSTS UNDER CURRENT LAW

Spending for Medicare is expected to exceed $200 billion this year, providing benefits to 39 million elderly or disabled people. Despite the recent slowdown in the growth of spending, outlays for benefits are expected to grow by more than 8 percent a year in the next decade.

At that rate, Medicare spending will account for almost 20 percent of the federal budget by 2009, up from about 12 percent in 1999. Medicare's share of the budget will continue to increase rapidly thereafter under current law, partly because of the influx of the baby-boom population. According to the intermediate assumptions of the Social Security trustees, the elderly population will increase by about 1 percent a year between 2000 and 2010 but will increase by almost 3 percent a year between 2010 and 2030—rising from 39 million to 69 million people. And, as in the past, Medicare's costs will probably grow faster than its enrollment, reflecting

continuing advances in medical technology and increases in the use of services by enrollees.

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

CONSIDERATIONS FOR RESTRUCTURING MEDICARE

Medicare enrollees now make up about 14 percent of the population and will reach 22 percent by 2030. Medicare pays for about 30 percent of all spending for hospital and physician services and for about half of all home health care. Thus, changes in

Medicare have consequences far beyond the federal budget, substantially affecting the private health care market as well, for better or worse.

The key to improving Medicare's efficiency lies in the payment system and the incentives it produces for participating health plans, providers, and enrollees. Those incentives should be consistent with the multiple goals that policymakers have for the program. Medicare's main goal is to ensure that enrollees can obtain medically necessary care of reasonable quality in the most appropriate clinical setting. An important secondary goal is to obtain such care at the lowest feasible cost. Additional goals—which might ultimately help to achieve the main objectives—could include expanding the type and number of plans from which enrollees may choose, ensuring that options in addition to fee for service are available in rural areas, and establishing the basis for a more competitive Medicare system in the future. The Congress began to address those additional goals through the BBA.

For a competitive system to be viable, Medicare's payment methods must adequately compensate participating health plans and providers while giving them incentives to control costs. That means that plans or providers must bear some financial risk—earning greater returns by providing services efficiently and smaller returns when inefficient. Large health plans may be able to assume full financial risk for their enrollees, but smaller plans may require limits on the risk they assume—an important consideration in designing such a system.

In addition, Medicare's traditional fee-for-service sector will be a major part of the program for the foreseeable future. Consequently, efforts to control costs cannot ignore that sector. A major focus of the BBA was to change the financial incentives facing fee-for-service providers, largely by expanding prospective payment systems. Further efforts to control costs in the fee-for-service sector may need to focus on changing the financial incentives facing enrollees.

ENHANCING COMPETITION IN MEDICARE

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

But the BBA left in place the administered pricing system, which sets Medicare's payments to plans. Consequently, the program has no meaningful price competition among plans for the basic benefit package. Instead, plans have incentives to increase optional benefits rather than to reduce costs, just as they did before the BBA. Therefore, even though enrollees benefit from the greater efficiency of risk-based plans than of the fee-for-service sector, Medicare does not.

Changing to a premium-support or bidding system could expand competition to include price as well as benefits and quality of service, so that Medicare could capture some of the savings from plans' more efficient health care management. Many issues would have to be resolved, however, before Medicare could implement such an approach nationwide. The competitive bidding demonstrations mandated by the BBA, if successfully implemented, could provide some answers.

In its first year, Medicare did not succeed in attracting more types of plans to the M+C system, largely because of the lead time plans need to develop new markets and because of uncertainties about key elements of the regulations governing the plans. In fact, the number of plans dropped appreciably in some areas—a response to lower payment updates than in past years in many local markets, the complexity of new program rules, and earlier deadlines for submitting premium proposals to the Health Care Financing Administration (HCFA). Some plans withdrew from markets where the plans had low enrollment and their financial viability was doubtful even before the changes implemented by the BBA. One facet of the changes made under the BBA—the payment rate floor and the move toward national rates—will probably tend to reduce the rate of enrollment growth in urban markets, and it may not attract plans to less populated areas.

Plans with low enrollment are especially vulnerable to losses from the unexpected use of services by a few seriously ill people because such plans may

have too few enrollees with below-average health needs to offset those with high needs. Eliminating all such risk would be undesirable since financial risk promotes more efficient practices. Nonetheless, undue vulnerability to financial risk could be reduced in the following ways:

- *Payment adjusters*. Currently, HCFA uses demographic factors for age, sex, Medicaid receipt, and institutionalization to adjust payments to plans for the expected costs of their enrollees. Beginning in 2000, HCFA will add an adjuster based on prior inpatient admissions to better account for health status. However, a payment adjustment based on prior inpatient admissions creates an obvious way for plans to increase their Medicare payments by hospitalizing enrollees unnecessarily—a problem that HCFA is well aware of. Consequently, HCFA plans to develop a more comprehensive health status adjuster as soon as possible.

- *Partial capitation.* Because even the best payment adjuster can account for only a modest amount of variation in health spending at the plan level, the Medicare Payment Advisory Commission (MedPAC) and others have suggested that some kind of partial capitation may be necessary to ensure that plans do not skimp on the services provided to their enrollees. Partial capitation could be

introduced by blending a capitated rate and a fee-for-service rate, supplementing payments for cases that are outliers, providing stop-loss protection on total costs at the plan level, or carving out selected high-cost services. All but the first of those approaches would reduce the capitation rate across the board, imposing a kind of premium on plans in return for insurance against excessive risk.

REFORMING FEE-FOR-SERVICE MEDICARE

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

Policies Affecting Providers

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

Prospective payment could be expanded. One example of doing so is bundling together acute and postacute hospital services. Another example is combining payments for physician and facility services during a hospital stay. However, developing viable prospective payment systems is difficult. More comprehensive bundles of services reduce the opportunity to shift services to sites or times not included in the prospective payment, increasing incentives to reduce costs; but such bundling also imposes greater financial risk on providers. One way to reduce excessive risk and the resulting incentive to avoid difficult cases is by including severity adjustments in the payment system, similar to the risk adjusters applied to capitation rates paid to M+C plans.

Policies Affecting Enrollees

Enrollees in Medicare's fee-for-service sector have to pay part of the costs of their covered services and all of the costs of prescription drugs, which are not typically covered by Medicare. In principle, cost sharing gives patients an incentive to use services more prudently. For several reasons, however, Medicare's cost-sharing requirements are not as effective in that regard as they might be. First, the requirements are too varied and complex to be well understood by patients. Second, some cases in which cost-sharing requirements could help reduce the inappropriate use of services (such as home health) have no such requirements; other cases, which have high cost-sharing requirements, have little possibility of adjusting the use of services (such as long hospital inpatient stays for severely ill patients). Third, because Medicare does not limit enrollees' cost-sharing liabilities, most enrollees seek some kind of supplementary coverage to limit their financial risk. Such supplementary coverage often eliminates the incentives for prudently using services that cost sharing is intended to create.

In its latest budgetary savings volume, CBO discussed one policy option that could better protect enrollees from catastrophic expenses and improve the effectiveness of Medicare's cost-sharing requirements. That option would change Medicare's cost-sharing requirements to more accurately reflect the costs of the services used and make them easier for enrollees to understand. It would also cap

each enrollee's annual liability for cost-sharing expenses. Medicare could implement the option for no net cost by raising cost-sharing requirements somewhat for the majority of enrollees who use relatively few services during the year and using those savings to finance the cost-sharing cap for the minority of patients with more serious health problems that year.

A complementary option, which would further increase the effect of Medicare's cost-sharing requirements, is to restrict the kind of coverage that medigap plans may provide. For example, medigap plans might be prohibited from covering Medicare's deductible amounts, or they might be permitted to offer only coverage for a lower cost-sharing cap than the one provided under Medicare—one set at $1,000 a year, for example, when Medicare's cap was set at $2,000. Restricting medigap coverage could generate considerable savings for Medicare, which pays most of the costs of the additional services used by medigap policyholders. Those savings could be used either to reduce the deficit or to improve Medicare's benefits. For example, they might be used to finance the costs of a prescription drug benefit.

CONCLUSION

The BBA introduced changes to both Medicare's risk-based and fee-for-service sectors that have slowed the growth in costs. But further action is needed to maintain Medicare's financial viability in the decades ahead.

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

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

Medicare could be restructured to allow health plans to compete on price as well as on benefits and quality. Enrollees could be given better information on their health plan choices, including a report card that could help them assess the quality of care. Payment systems and cost-sharing requirements could be revamped to provide both plans and enrollees with clear financial incentives for efficiency. But the actions necessary to bring competition to Medicare are complex and require the effort and goodwill of everyone: plans, providers, enrollees, and policymakers. The discussion today could be an initial step in the direction of real reform.