Medicare's Long-Term Financial Viability

Testimony

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By

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

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

Medicare's Long Term Financial Viability

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

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

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

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

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

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

Medicare Prescription Drug Benefit

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

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

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

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

Some Next Steps

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

There are serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of seniors varies substantially across the country, far more than can

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

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

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

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

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

What Have We Learned About Controlling Spending in Medicare?

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

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

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

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

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

Conclusions

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

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

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

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

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

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

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

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

As we contemplate a Medicare program for the 21st Century, it is important to understand that the people who will be reaching 65 during this decade as well as the baby-boomers, themselves, have had very different experiences compared to today's seniors. Most of them have had health plans involving some form of managed care, many of them have had at least some experience choosing among health plans, most have had more education than their parents and many will have more income and assets. The biggest change involves the women who will be turning 65. Most of these women will have had substantial periods in the labor force, many will have had direct experience with employer-sponsored insurance and at least some will have their own pensions and income as they reach retirement age. This means that we need to think about tomorrow's seniors as a different generation, with different experiences, with potentially different health problems and if we start the reform process soon, with different expectations.