

Statement of Gail R. Wilensky, Ph.D.

Mr. Chairman and members of the Aging Committee, thank you for inviting me to appear before you. My name is Gail Wilensky. I am a John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I chair the Medicare Payment Advisory Commission. I am also a former Administrator of the Health Care Financing Administration. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences running HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or MedPAC.

I am here to support the Breaux-Frist proposal. Their proposal, the Medicare Preservation and Improvement Act of 1999, is an example of the direction of reform Medicare needs to take. Although I believe there are some problems that remain with the proposal, which I summarize in my testimony, the changes move Medicare in the right direction by providing better incentives to seniors and providers and by linking a new drug benefit to overall reform.

Under the Breaux-Frist proposal, seniors could choose from competing health plans to obtain their health services. Seniors would have the option of selecting a basic health plan, which covers current Medicare benefits, or a high option plan that also includes coverage for outpatient prescription drugs and a stop-loss benefit. In addition to competing private standard and high option plans, there would also be a HCFA-sponsored standard and high option plan, thus allowing seniors who wished to, the ability to remain in traditional Medicare. Low income populations (seniors under 135% of the poverty line) would get full Federal funding for the lowest-cost high option plan in their area. Other low-income seniors would get a sliding scale subsidy for drug benefits.

The Need for Reform

Medicare's popularity as a social program notwithstanding, the program is in major need of reform. Although Medicare solved the primary problem it was designed to address, ensuring that seniors had access to health care, there are a variety of problems with Medicare as it is currently constructed.

Much of the motivation for Medicare reform has been financial. Medicare, as it is currently structured, is partially dependent on a Part A trust fund that is currently projected to be depleted of funds just as the pressure of the baby boomers retirement starts to be felt. The April 1999 report of the Social Security Trustees, the latest official estimates, moved the date of depletion from 2010 to 2015. This estimate, however, is very fragile. The additional five years of Part A solvency are based on razor-thin surpluses over several years that could easily disappear if Part A expenditures increase slightly faster than anticipated or wage tax revenue grows slightly slower than anticipated. In addition, the pressure on general revenues from Part B growth will continue although this is less observable since Part B is not funded by a stand-alone trust fund. Although the economy is remaining strong, with substantial budget surpluses being projected over the next ten years, the realized surplus will be highly dependent on the amount which discretionary spending is allowed to grow.

However, the motivation for Medicare reform is and should be more than financial. Traditional Medicare is modeled after the indemnity insurance plans that dominated the way health care was organized and delivered in the 1960's. The benefit package also reflects the 1960's, not covering outpatient pharmaceuticals or protection against very large medical bills.

Because of the limited nature of the benefit package and, at least until recently, the restricted nature of plan choices allowed under Medicare, almost all seniors supplement traditional Medicare. The use of

this two-tiered insurance strategy has had important consequences for both seniors and for the Medicare program. For many seniors, it has meant substantial additional costs, with annual premiums varying between \$1000 and \$3000 or more.

The supplemental plans have also meant additional costs for Medicare. By filling in the cost-sharing requirements of Medicare, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in the greater use of Medicare-covered services and thus increased Medicare costs.

In addition to concerns about the incentives associated with Medicare, there are also issues of equity. The amount Medicare spends on 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. Since seniors and others pay into the program on the basis of income or wages and pay the same premium for Part B services, this results in substantial cross-subsidies from people living in low cost states and states with conservative practice styles to people living in higher cost states and states with aggressive practice styles.

The Direction of Reform

I believe a program modeled after the Federal Employees Health Benefits Program or what is now generically referred to as a premium-support program, such as the Breaux-Frist proposal, would provide a better structure for Medicare. Such a program could produce a more financially stable and viable program, and would provide better incentives for seniors to choose efficient plans and/or providers and better financial incentives for physicians and other health care providers to produce high-quality, low-cost care. This type of program would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program, for the plan that suited their needs. It also includes outpatient prescription drug coverage as part of overall Medicare reform.

I am well aware that the premium support model remains controversial among some Members of Congress. However, I think it is important that committee members understand that many of the most vexing issues that need to be resolved for a premium support program must also be resolved for the current Medicare program. This will remain true as long as the Medicare program includes a traditional fee-for-service benefit and a variety of Medicare replacement programs. These include such issues as risk adjustment, providing understandable and user-friendly information to seniors, assuring that quality care is being delivered and providing safeguards for frail and vulnerable populations.

Some are raising questions about the difficulties surrounding the Medicare+Choice program and what that portends for premium support. Although the Medicare+Choice program continues to grow, the growth rate has slowed down dramatically.

Understanding the problems being experienced by Medicare+Choice may help to prevent them from occurring in a premium support program. In some cases, plans just made bad business decisions. They went into too many markets or tried to enter markets where they were unable to form networks. Plans also found special problems entering rural areas, especially those with a single hospital or a few dominant provider groups. Finding ways to make more plan choices available in rural areas will clearly need more effort.

But other problems reflect actions by the government that can and should be addressed. There is substantial uncertainty about the "rules of the road" - new regulations and requirements, reimbursement changes, changing models of risk adjustment, etc. Equally disturbing is the growing differential in

spending rates for Medicare services in traditional Medicare versus spending in Medicare replacement plans. These are issues that need to be resolved for Medicare+Choice as well as a premium support model.

Getting From "Here" to "There"

Historically, changes in Medicare reimbursement policy and structure have been phased in over several years. This has helped to cushion the disruption that abrupt changes could cause. It also makes sense to consider phasing-in changes in the structure or organization of a reformed Medicare program that requires substantially different roles for government or substantially different roles for the administrative institutions supporting the program such as exists with premium support. Any interest in experimenting with various strategies for reform or the administrative structures supporting reform makes it even more urgent that we begin the process now.

Concerns have been raised about instituting significant changes in a program involving the elderly. Many of today's seniors have had little experience with health plans other than fee-for-service indemnity plans, many seniors have modest incomes and some have little education. Whatever changes are made to the Medicare program may need to be modified for at least some subsets of the existing seniors population. Some groups of seniors may need to be excluded from any change.

Because of the difficulties that come with changing programs involving seniors, it is important that we establish now where we want to go with a reformed Medicare program.

It is also important to understand that the people who will be reaching age 65 or over the next decade as well as the baby-boomers have had very different experiences relative to today's seniors. Most of them have had health plans involving some forms 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 we need to think about tomorrow's seniors as a different generation, with different experiences, with potentially different health problems, and if we start soon, with different expectations.

The Administrative Structure Supporting a Reformed Medicare

At least two major administrative issues need to be addressed. The first involves using a Medicare Board as the major administrative structure supporting a premium support type of program. The second involves the potential role of the Health Care Financing Administration in running a modernized fee-for-service Medicare program.

I support the notion of a separate Medicare Board that would oversee and perhaps negotiate with private plans and the traditional Medicare program. As proposed, the most important functions of such a Medicare Board would be to review and approve benefit packages, to negotiate premiums, make payment modifications (such as risk adjustment), direct open enrollment periods and to provide information about plan choices. Giving the Board the ability to negotiate premiums and specify benefits runs the risk of making the Medicare Board a super HCFA and should be considered carefully. The oversight does not pose this risk..

While I think it is appropriate and proper that the individuals who have been involved in administering

the Medicare+Choice program at HCFA be moved to the Board, it is important to have a Board that is separate from HCFA and with leadership from outside of HCFA. It would be desirable to include people with experience administering the FEHB program, the CalPERS program and some of the more comparable programs from the private sector.

Among the many reasons a separate Medicare Board is desirable is that the mind-set of HCFA is focused on running a publicly administered, price-setting, fee-for-service system. The functions and roles for government in running and monitoring a premium support system are so fundamentally different from the experiences and mind-set of HCFA personnel that it would detract from rather than enhance the successful operations of a premium-support program.

A more difficult issue is whether HCFA or any governmental entity could administer a modernized fee-for-service system that competes effectively with privately administered plans. A series of changes would be needed to modernize the traditional Medicare program. These include the use of selective contracting, centers of excellence, disease management programs, best practice programs, variations in benefit structures and other changes that are commonplace in the better-run private sector plans.

The question in my mind is whether the Congress will allow HCFA the flexibility that would be needed to run such a program and whether the Congress and the Administration will provide HCFA with the resources needed to carry out such a task. History is not encouraging on either of these issues.

If HCFA or any other governmental agency is to run a modernized fee-for-service program, Congress will need to change its relationship with HCFA and retreat from its very micro-prescriptive directives. This would require both changes in statute and changes in attitude. It would also require changes in attitude and behavior by the employees of HCFA. Demonstration and/or adoption of promising ideas from the private sector have been painfully slow to be undertaken by HCFA. Some of this slowness may be caused by political difficulties associated with these strategies, such as the selective exclusion of providers, or by a lack of appropriate funding. But too often it appears to be the results of bureaucratic inaction and indecision.

An alternative to a publicly-administered, modernized fee-for-service Medicare program is the use of competitively-procured, private fee-for-service plans. These plans could be bid out on a risk basis at a national, regional or state level with plans using administered pricing if they chose to do so.

The attraction of the privately administered fee-for-service plans is that they can introduce changes in local markets that HCFA may not be able to do. But for many people, this is also the fundamental drawback of the privately administered plans. The public oversight and control of a publicly administered plan provides a sense of protection that will be difficult to ignore and at least to me, the political objections likely to result from eliminating a publicly administered traditional Medicare program, seem overwhelming.

This means that if there is to be a publicly-administered, modernized fee-for-service component to a premium support program, which I think is both desirable and politically necessary, Congress will need to change its relationship with HCFA and grant it more flexibility than it has done in the past. In return, HCFA will need to be more responsive, more pragmatic and more creative in its behavior.

Unresolved Issues and Other Remaining Problems

While the Breaux-Frist proposal represents an important step towards reforming the Medicare program, there are some problems with the proposal in the short term and some issues that have not yet been

addressed but which will need to be addressed in the long term.

There are at least two important issues that should be addressed in the short term. The first is the inclusion of a stop-loss provision for outpatient prescription drugs. The easiest and most appropriate way to address this issue is to provide a single, somewhat higher stop-loss provision that includes both current Medicare benefits and prescription drugs although it would be possible to begin with two separate stop-loss provisions and have them converge into a single measure over time.

A second issue involves the use of a temporary prescription drug benefit for the lowest income populations until such time as the Congress is ready to pass and/or implement major Medicare reform. This could include a block grant program loosely based on the SCHIP model, a prescription drug benefit limited to the Qualified Medicare Beneficiary (QMB) and Selected Low Income Medicare Beneficiary (SLMB) populations, a block grant program to states to develop or expand state pharmacy assistance programs or some other model.

There are a number of other areas of concern, some of which were deliberately not included in this piece of legislation. Examples include the treatment of funding for graduate medical education, the appropriate age of eligibility, reform of the Medigap market and so forth. Questions have also been raised as to whether there are sufficient safeguards for rural areas. While all of these are legitimate questions, they can be addressed with subsequent legislation or by amending the current proposal if the Congress is ready to take on all of these issues at the present time.

Despite these shortcomings, the Breaux-Frist proposal represents an important step in the overall reform of the Medicare program.