Health Policy 2001

MEDICARE

THE Medicare program, which serves persons over the age of 65 years and many persons with disabilities, plays a large part in health care in the United States. Since the program was implemented, in 1966, the number of persons served has increased from 19 million to 40 million, and expenditures for Medicare have risen faster than those for any other major federal program. Medicare now insures one of every seven Americans.

Medicare remains at the forefront of political debate because of the aging of the baby-boom generation and the likelihood that health care expenditures will continue to increase. By 2030, the program is expected to serve 77 million people — more than one of every five Americans — and to account for about 4.4 percent of the gross domestic product.[1]

There are three major issues involving Medicare. First, since the late 1970s, legislators have sought to revise the program in order to improve its management and efficiency and thereby slow the growth in federal expenditures. Second, Medicare's benefit package is inadequate. Many beneficiaries rely on supplemental policies, which results in inefficient delivery of care.[2] Medicare does not cover outpatient prescription drugs, and the deductibles and copayments can be very expensive. Thus, about 85 percent of Medicare beneficiaries have some type of supplemental coverage. Even so, Medicare beneficiaries tend to pay more for their health care than do most other Americans — both in absolute dollars and as a share of their total health care expenditures. At present, the average beneficiary pays more than $3,000 out of pocket each year for health care (excluding long-term care).[3] Third, Medicare has not been as well financed as Social Security, leading to numerous fiscal crises.

These three issues overlap. For example, many of those who want to restructure Medicare also propose that the program provide additional benefits, such as coverage of prescription drugs. There are conflicting views about whether restructuring Medicare will fully resolve the financial problems,[4] however, and if the basic benefit package is expanded, the costs will increase even more.

HISTORICAL PERSPECTIVE

In 1965, before the establishment of Medicare, only about half of those in the United States who were 65 years of age or older had health insurance.[5] By 1970, 97 percent of older Americans were enrolled in the program, and that proportion has remained about the same ever since. Part A of Medicare covers inpatient services, skilled nursing care, and home health care. Part B covers outpatient and physicians' services.

The implementation of the Medicare program had two immediate effects. The use of health care services grew, and financial burdens on older Americans and their families declined.[6] Thus, access to health care increased, particularly for those with low incomes who had previously been uninsured. Although the Medicare benefit package has changed little since 1966, the program has generally kept up with changes in medical practice. In some cases, the use of new procedures and devices has grown at a faster pace in the care of older persons than in the care of younger persons.[7]

The increase in life expectancy in the United States since 1965 is undoubtedly attributable in part to Medicare. For a 65-year-old woman, life expectancy increased from 15.8 years in 1960 to 19.2 years in 1998; for a 65-year-old man, it increased from 12.8 years to 15.9 years.[8] In addition, life expectancy has increased at a faster pace for older persons than for the population as a whole. Whereas life expectancy for a 65-year-old man increased by 24.2 percent between 1960 and 1998, life expectancy at birth increased by only 7.6 percent. As life expectancy has increased, disability rates have declined, suggesting that these longer lives are also healthier lives.[9]

In 1965, elderly persons spent an average of about 19 percent of their income on health care. That share fell to about 11 percent in 1968; today, it is more than 20 percent.[3] Medicare copayments and premiums have risen by about 9 percent per year on average, a much faster rate of growth than that of income among beneficiaries.[10] Without Medicare, however, most people would pay even more for health care or go without it.

In the 1980s, Medicare shifted from a cost-based system of paying hospitals and doctors to one in which payments are predetermined, with hospitals receiving a flat rate that is based on the diagnosis. These and other cost-containment efforts, such as restrictions on the use of home health care and skilled nursing care, helped slow the growth in expenditures. As a result, per capita expenditures for Medicare beneficiaries increased more slowly than per capita expenditures for persons with private insurance, particularly in the late 1980s.[11] Moreover, per capita Medicare expenditures grew at a slower rate than per capita expenditures by the private health insurance industry from 1970 to 1997.[6]

In another effort to reduce expenditures, Medicare beneficiaries have been allowed to enroll in private health maintenance organizations (HMOs) instead of remaining in the traditional, fee-for-service program. On average, however, the costs have been higher for HMO enrollees than they would have been if the same enrollees had remained in the traditional

Downloaded from www.nejm.org at UNIV OF TEXAS on June 14, 2005 .
Copyright © 2001 Massachusetts Medical Society. All rights reserved.

program.[12] In 1997, this option was modified to expand the types of plans that could participate in Medicare and to reform the payment system. In December 2000, 6.3 million Medicare beneficiaries were enrolled in HMOs.[13] This program, called Medicare+Choice, has continued to be problematic. It has not reduced federal spending, nor has it provided stable coverage for those who have chosen it.[14] Even with payments high enough to cover Medicare's basic benefits, private plans have pulled out of some service areas and have restricted benefits. They have also resisted efforts to obtain data on the quality of care and to adjust payments in order to discourage adverse risk selection — that is, the selective enrollment of healthier beneficiaries.

Despite increased payments to Medicare+Choice plans, the problems are likely to continue. On January 1, 2001, about 934,000 people — approximately one of every six Medicare+Choice enrollees — lost coverage from their HMOs, forcing them either to seek coverage from other HMOs or to return to traditional Medicare coverage.[15]

SLOWING THE GROWTH OF PER CAPITA SPENDING

Since the 1980s, slowing the growth of Medicare spending has been a high priority for federal legislators, although the urgency has diminished in recent years as the growth in spending has slowed. In 2000, it was predicted that funds for Part A of Medicare would be exhausted by 2025[1]; in 1996, the estimated date was 2001.[16] Historically, premiums for Medicare and those for private insurance plans have shown similar trends in growth despite the slower rate at which Medicare expenditures have grown. This suggests that Medicare cannot be treated differently from the rest of the health care system over a long period.

Nonetheless, several alternative approaches to reducing per capita Medicare expenditures remain under discussion. These range from incremental changes to major structural reforms that would place Medicare under the control of private health plans. Most of the incremental approaches seek to modernize the fee-for-service portion of Medicare and to reform the way in which Medicare+Choice premiums are set. Critics charge that incremental approaches focus too much on cutting payments for health care services and ignore the need to control their use. But management techniques used by private insurers could be adopted for use in the traditional Medicare program. For example, in 1999, President Bill Clinton proposed that this program contract with a limited number of providers of high-technology procedures, that suppliers of health care products be required to bid for Medicare contracts, and that case-management and disease-management programs become part of traditional Medicare.[17]

The principal proposal for restructuring Medicare is a variant of the 1999 plan considered by the National Bipartisan Commission on the Future of Medicare.[18] Termed "premium support," this approach would require that beneficiaries choose among an array of private plans (with traditional Medicare being just one choice). If the cost of the chosen plan exceeded the national average cost (or some other designated benchmark), the beneficiary would have to pay a higher premium. The goals of this approach are to make beneficiaries more sensitive to the costs of health care and to create stronger incentives for private plans to limit costs. But this approach might lead to adverse risk selection — that is, the traditional Medicare program might become more expensive than private plans because it would serve the patients with the most serious medical disorders. If so, traditional Medicare — now effectively the default plan for many persons — might become unaffordable, forcing beneficiaries to enroll in managed-care plans. Premium-support proposals are based more on theory than on practice, so it is not known whether adjustments to prevent adverse risk selection would be effective.

No proposed reform of Medicare will magically lead to lower costs. What ultimately matters is changing the main determinants of cost: the prices charged for services, administrative costs, and the number of services delivered.

Medicare has always been competitive with the private sector in limiting what it pays for services, particularly in the key areas of payments to hospitals and payments to physicians. Moreover, Medicare has done a better job of controlling administrative costs than private plans have. On the other hand, private plans can be more flexible than Medicare. If a troubling pattern in service delivery is identified, a private plan can decide not to renew contracts with doctors or hospitals.[19] Similarly, private plans can adopt new computer systems or other innovations more rapidly than Medicare can. To operate well, the traditional Medicare program needs more flexibility, but it will probably always have to meet higher standards of due process for providers and patients. Because of this constraint, the Medicare program may remain more costly, but it can also offer legal protection for both providers and beneficiaries.

The most important determinant of cost is the number of services used, particularly if they include expensive new forms of medical technology. Both Medicare and private plans have difficulty distinguishing between appropriate and inappropriate care and then finding ways to reduce the use of services considered to be inappropriate. Under traditional fee-for-service coverage, providers have incentives to offer more rather than fewer services.

In contrast, managed-care organizations should have an advantage in coordinating care, since they have a financial responsibility to keep health care costs

Downloaded from www.nejm.org at UNIV OF TEXAS on June 14, 2005 .
Copyright © 2001 Massachusetts Medical Society. All rights reserved.

within a specific budget. However, many HMOs, particularly those with loose organizational structures, have not made the effort necessary to manage and coordinate care effectively.[20] Over time, some plans may improve their management techniques, thus establishing a case for further privatization of Medicare, but most have not done so. Furthermore, recent problems with Medicare+Choice suggest that private insurance plans are not serving Medicare beneficiaries well. When these plans change the benefits they offer or withdraw from a city or region of the country, they disrupt the health care of the people they serve.

The dissatisfaction of patients and physicians with managed care suggests that Medicare reforms that rely on greater market competition should be undertaken cautiously. Other changes, such as adopting better payment methods for private plans (including adjustments for adverse risk selection) and developing reasonable requirements for reporting on the quality of care, need to be made to ensure the effectiveness of competition.

In addition, improvement in guidelines for care is important, regardless of Medicare's structure. A substantial commitment of public resources may be needed for outcomes research, disease-management programs, information for beneficiaries on the effectiveness of care, and other approaches to improving the quality of care and reestablishing patients' trust in Medicare. Patients also need credible sources of information if they are to choose their health plans wisely. So far, however, there has been little interest in investing in any of these measures.

REDUCING THE NUMBER OF BENEFICIARIES

Another way to reduce Medicare expenditures is to reduce the number of people covered by the program. Increased life expectancy makes each generation of beneficiaries eligible for more years of Medicare coverage. One approach to increased longevity would be to raise the age at which persons become eligible for Medicare. Another approach would be to establish an annual maximal income for eligibility (i.e., means testing). However, both these options are controversial. President George W. Bush promised during the 2000 election not to raise the age of eligibility. Whenever means testing is suggested as a way to exclude persons with high incomes from Medicare coverage, there is strong opposition from advocates of universal coverage, who fear that means testing would undermine support for the entire program.

There are also practical problems with those approaches. Persons who are 65 or 66 years old account for only 5 percent of Medicare beneficiaries. If they were no longer eligible for coverage, the savings would represent only 2 or 3 percent of total Medicare expenditures. Persons in this age group use fewer services and thus are less expensive to insure than those who are older.[21] With means testing, eligibility must be determined. If the criterion for eligibility were an income no higher than $30,000, the most feasible mechanism for establishing eligibility would be the income tax, an unpopular idea that in the past has killed such proposals. If a lower income level were used, many beneficiaries would lose their Medicare coverage and be unable to afford private coverage. Thus, reforms of the insurance market would be required to guarantee that newly disenfranchised beneficiaries could obtain insurance, and at a reasonable price.

ADDRESSING THE INADEQUACY OF THE BENEFIT PACKAGE

The Medicare benefit package is inadequate because it leaves beneficiaries liable for nearly half the cost of their acute care. The current deductible for hospitalization is $792. In addition, beneficiaries must pay 20 percent of their physicians' fees; there is no annual cap on the amount. Because of these high out-of-pocket expenses, 85 percent of beneficiaries have supplemental insurance.[2] Medicaid (which 15 percent of Medicare beneficiaries have) and employer-sponsored retirement benefits do a good job of filling in the gaps. Employer-sponsored plans are now used by about a third of Medicare beneficiaries but are becoming less available. Private supplemental (Medigap) plans — which serve about one fourth of beneficiaries — are becoming unaffordable for those with an average income. For example, in Dallas, Medigap plans that offered minimal drug coverage for a 65-year-old person ranged in price from $1,500 to $3,900 in 1998. The ranges are similar in other cities, and for older persons the costs are even higher. Premiums for Medigap plans increased by 35 percent between 1994 and 1998.[22]

Medications are a critical part of a comprehensive health care system. Medicare beneficiaries are finding it increasingly difficult to pay for prescription drugs, particularly because they also have other health care expenses. Adding only drug coverage to the benefit package, however, is unlikely to be enough to encourage beneficiaries with traditional Medicare coverage to forgo supplemental insurance. To achieve this goal, further revisions, such as establishing an upper limit on cost sharing and reducing the deductible for hospital services, would be needed. In addition, without a comprehensive benefit package that will attract patients with serious medical conditions as well as those who are relatively healthy, adverse risk selection is likely to undermine competition.[2] Plans with generous prescription-drug benefits, for example, will tend to attract the sick. But if all plans had to offer a basic drug benefit and if payments from Medicare to these plans were increased to reflect the new benefit, competition might improve. Thus, although there is general agreement on the desirability of improving

Downloaded from www.nejm.org at UNIV OF TEXAS on June 14, 2005 .
Copyright © 2001 Massachusetts Medical Society. All rights reserved.

coverage, the higher costs of such changes are still a major impediment.

THE FUTURE OF MEDICARE

Given the conflicting views on how to change Medicare, what direction will Congress and the Bush administration take? Medicare's improved financial outlook and Bush's campaign promise to provide prescription-drug coverage probably mean that cost containment will get little attention. In fact, the fallout from earlier efforts to reduce costs will probably continue, with hospitals and HMOs seeking yet another round of increased payments. The biggest unknown is whether those who seek a structural reform of Medicare will make such changes a condition for enacting prescription-drug coverage. This tactic could stall legislation, since there is little agreement on the best approach to an overall reform of the program. A key issue is how traditional Medicare would be treated under such a reform. If there were no special protection for this part of the Medicare program, political stalemate would be likely. An approach to reform that kept the current system largely intact but established a better way of paying private plans could generate savings and protect the traditional program. The option of increasing competition would remain open. The program is on solid financial footing for the next 10 years, so there is time for incremental changes.

Ultimately, none of the reforms now under consideration are likely to solve the problem of how to finance Medicare after the next decade. The question, then, is who will pay for the health care of older Americans and those who are disabled — beneficiaries or taxpayers? Even with higher contributions from beneficiaries and successful cost containment, in the long run, Medicare will require additional public funds.[4] Reducing the number of beneficiaries or the scope of coverage would shrink the federal liability but do little to reduce the societal costs of financing health care. The basic issue will be how to share that burden.

MARILYN MOON, PH.D.
Urban Institute
Washington, DC 20037

REFERENCES

1. Board of Trustees of the Federal Hospital Insurance Trust Fund. Annual report of the Federal Hospital Insurance Trust Fund. Washington, D.C.: USGPO, 2000.
2. Aaron HJ, Reischauer RD. The Medicare reform debate: what is the next step? Health Aff (Millwood), 1995;14(4):S-30.
3. Maxwell S, Moon M, Segal M. Growth in Medicare and out-of-pocket spending: impact on vulnerable beneficiaries. New York: Commonwealth Fund, January 2001.
4. Gluck M, Moon M. Financing Medicare's future. Washington, D.C.: National Academy of Social Insurance, 2000.
5. Andersen R, Lion J, Anderson OW. Two decades of health services: social survey trends in use and expenditure. Cambridge, Mass.: Ballinger Publishing, 1976.
6. Moon M. Medicare matters: building on a record of accomplishment. Health Care Financ Rev 2000;21:9-22.
7. *Idem.* Beneath the averages: an analysis of Medicare and private expenditures. Menlo Park, Calif.: Henry J. Kaiser Family Foundation, September 1999. (See www.kff.org/content/1999/1505/moonbeneath.pdf.)
8. National Center for Health Statistics. Health, United States, 2000. Hyattsville, Md.: Public Health Service, May 2000.
9. Manton KG, Corder LS, Stallard E. Estimates of change in chronic disability and institutional incidence and prevalence rates in the U.S. elderly population from the 1982, 1984, and 1989 National Long Term Care Survey. J Gerontol 1993;48:S153-S166.
10. Medicare and Medicaid statistical supplement, 1999. Health Care Financ Rev 1999.
11. Levit K, Cowan C, Lazenby H, et al. Health spending in 1998: signals of change. Health Aff (Millwood) 2000;19(1):124-32.
12. Riley GF, Ingber MJ, Tudor CG. Disenrollment of Medicare beneficiaries from HMOs. Health Aff (Millwood) 1997;16(5):117-24.
13. Cassidy A, Gold M. Medicare+Choice and Medicare beneficiaries, monthly tracking report for December, 2000. Washington, D.C.: Mathematica Policy Research, January 2001.
14. The Barents Group. How Medicare HMO withdrawals affect beneficiary benefits, costs, and continuity of care. Menlo Park, Calif.: Henry J. Kaiser Family Foundation, November 1999. (See www.kff.org/content/1999/1547/disenrollee11-5-99.pdf.)
15. Thomas J. H.M.O.'s to drop many elderly and disabled people: health experts predict most severe consequences will be loss of prescription drug benefits. New York Times. December 21, 2000:A14.
16. Annual report of the Board of Trustees of the Federal Hospital Insurance Trust Fund. Washington, D.C.: USGPO, June 1996.
17. National Economic Council. The President's plan to strengthen and modernize Medicare for the 21st century. Office of the President, July 2, 1999.
18. National Bipartisan Commission on the Future of Medicare. Building a better Medicare for today and tomorrow. U.S. Congress, March 16, 1999.
19. Center for Studying Health System Change. Wall Street comes to Washington: market watchers evaluate the health care system. Issue Brief no. 31, Washington, D.C., September 2000.
20. Lesser CS, Ginsburg PB. Update on the nation's health care system: 1997-1999. Health Aff (Millwood) 2000;19(6):206-16.
21. Waidmann TA. Potential effects of raising Medicare's eligibility age. Health Aff (Millwood) 1998;17(2):156-64.
22. Medicare: new choices, new worries. Consumer Reports. September 1998:27-38.

Copyright © 2001 Massachusetts Medical Society.

IMAGES IN CLINICAL MEDICINE

The *Journal* has resumed consideration of new submissions for Images in Clinical Medicine. Instructions for authors and procedures for submissions can be found on the *Journal*'s Web site at www.nejm.org. At the discretion of the editor, images that are accepted for publication may appear in the print version of the *Journal*, the electronic version, or both.

Downloaded from www.nejm.org at UNIV OF TEXAS on June 14, 2005 .
Copyright © 2001 Massachusetts Medical Society. All rights reserved.