RESTRUCTURING MEDICARE FOR THE LONG TERM PROJECT

Final Report of the Study Panel on
Medicare's Larger Social Role

Medicare and the American Social Contract

February 1999

NATIONAL ACADEMY OF SOCIAL INSURANCE

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Foreward

The Study Panel on Medicare's Larger Social Role was convened in January, 1997 as one of the four panels formed by the National Academy of Social Insurance (NASI) to contribute to the work of its ongoing project *Restructuring Medicare for the Long Term*. Each of the four panels concentrated on a specific aspect of Medicare; the Study Panel on Capitation and Choice and the Study Panel on Fee-For-Service Medicare have completed their work, the Study Panel on Medicare Financing will complete its work in 1999.

This Panel was charged with examining the philosophical principles and rationales that underlie Medicare and the ways in which the program fits into the larger social insurance and welfare structures. The Project Steering Committee Panel asked Panel members to address the question, "*What social values is the nation trying to pursue through Medicare, recognizing that government maintains other programs to help the aged and disabled?*"

The Panel included experts from business, government, labor and applied research and academia, from the fields of history, philosophy, political science, medicine, economics, sociology, business management, and social work. It met four times between January, 1997 and May, 1998. To help in its discussions, the Panel commissioned three papers, "Medicare for the 21st Century: The Goals of Health Coverage for Our Aging Society," by Christine K. Cassel and Lydia Siegel, Mt. Sinai Medical Center; "The Sacred Social Whatever: The Once and Future Medicare Contract" by Lawrence D. Brown, Columbia University; and "The Social Roles of Medicare" by Michael Gusmano, Yale University, and Mark Schlesinger, Yale and Rutgers Universities. Since the public's perceptions of Medicare were central to the Panel's work, it also conducted a national public opinion poll and a series of focus groups that allowed it to pursue specific questions about the relationships among social values, understanding of the program, and perspectives on Medicare reform.

The Panel agreed early on in its discussions that the most important thing it could contribute was a clear description of what Medicare is, and how it has been viewed over time by the public and by policymakers. To what extent is it seen as a social insurance program? A health program? A guarantor of income security in disability and old age? The Panel asked how Americans characterize the value of the program to them and to their families. It also examined how Medicare functions both as a public program, on the one hand, and as a vital support to the largely private health care system on the other. Medicare also fills wider social roles including providing support for graduate medical education, hospitals serving a disproportionate share of poorer Americans and facilities in rural areas, and for health services and medical effectiveness research. All of these activities benefit a wider population than Medicare beneficiaries.

This report is designed as a primer for further discussion. In preparing it, the Panel was concerned that Medicare reforms could be adopted to address short-term problems without a full appreciation or understanding of the principles and assumptions on which Medicare is based, the intertwining of Medicare with other public and private health care and income support

programs, and the possible long-term consequences of actions based on short-range vision. There is no magic bullet to cure Medicare's ills, but the nation should not inadvertently compound those ills. Informed discussion is the first step to improving Medicare for both the long and short term, in ways that seem fair to the whole population.

Accordingly, this report includes an overview of Medicare, its problems and its strengths. It reviews public attitudes and understanding of the program. It suggests criteria that readers can use to identify the values that they believe should be preserved or strengthened as Medicare is reformed. It provides a guide to how the major proposals embody these values.

Medicare is a huge, complex, expensive program that has become a vital part of the American infrastructure. The Panel hopes that this report will stimulate and clarify public debate in a policy area that is too often confused and conflicted.

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Executive Summary

The Steering Committee for the National Academy of Social Insurance project *Restructuring Medicare for the Long Term* convened the Study Panel on Medicare's Larger Social Role in January, 1997, with a charge to examine the underlying principles and rationales of Medicare and how the program fits into the larger social insurance and welfare structures. Panel members were asked to address the question,

"What social values are we trying to pursue through Medicare, recognizing that the federal government relies on programs to help the aged and disabled?"

The Panel on Medicare's Larger Social Role is the third of four panels formed by the National Academy of Social Insurance (NASI) to contribute to the work of its ongoing project *Restructuring Medicare for the Long Term*. The four panels concentrated on specific aspects or elements of Medicare; the Study Panel on Capitation and Choice and the Study Panel on Fee-For-Service Medicare issued reports in early 1998, and the Study Panel on Medicare Financing will complete its work in 1999. Chaired by Rosemary A. Stevens, Stanley I. Sheerr Professor of History and Sociology of Science at the University of Pennsylvania, the Social Roles Panel (listed at the front of the report) includes experts working in business, government, labor and applied research and academia, the fields of history, philosophy, political science, medicine, economics, sociology, business management, and social work. The Panel met four times, commissioned background papers, and conducted targeted research, including a national poll in the early summer of 1997, and a series of ten focus groups conducted in three regions of California in February, 1998. This report has been written to help policy makers and others with an interest in Medicare and public policy frame the broader discussions that need to take place about this complex, highly-valued program. More detailed analysis of issues and options related to financing health care for Medicare beneficiaries will be made in available in reports of the Academy's Panel on Medicare Financing.

ORGANIZATION OF THE REPORT

The report is divided into four parts:

- A review of why Medicare was created, how it has grown and changed over time, and the challenges that the program faces now and for the longer-term,
- An assessment of the principles of social insurance embodied in Medicare, and of the roles Medicare has assumed as a major social insurance program and, because of its unique role in the American health care system, as a vehicle for other social policy goals,
- An analysis of the American public's views of Medicare and of public and individual responsibility; its understanding of the program; and the work that needs to be done to make it possible to have meaningful national discussions about the future of Medicare as social insurance, and
- A discussion of criteria, derived from expressed values and policy concerns, that can be used to evaluate options for Medicare reform, together with illustrations of the issues that emerge when these criteria are used as a frame-

work for evaluating alternative Medicare reform proposals.

KEY FINDINGS

Medicare was created as a response to a serious problem: The private market did not and could not work for a large proportion of the nation's elderly and disabled population. Medicare provided a means of insuring tens of millions of Americans who otherwise could not afford health insurance.

- Medicare has improved the health status of the elderly in America. The program has reduced the burden of responsibility for medical care costs for families and provided access to health care that extends life and increases the quality of life for millions of people.
- Medicare's ability to fulfill its goals is now threatened from two opposite directions by the same basic problem: health care costs. Projected health care expenditures exceed the revenues available to fund the program as it is currently structured much beyond the next decade. At the same time, the program is falling behind in its goal of providing financial security to beneficiaries and their families. Out-of-pocket health care costs for elderly Medicare beneficiaries (excluding those living in nursing homes) now amount, on average, to about 19 percent of annual household income.
- Although the aging of the population has contributed to the problems that Medicare is facing, there is convincing evidence that the major factor driving the relentless growth of Medicare outlays is the increasing use of services for the average beneficiary. Failing to recognize the underlying cause of increases in health care costs could lead to the adoption of policies that might deny much of the Medicare population the benefits of future medical advances, whether by rationing by price, by beneficiaries' ability to pay, or by excluding coverage for some services.
- The costs and benefits of redesigning Medicare's benefit package need to be analyzed carefully and in view of the total health care costs that will ultimately be borne by beneficiaries, families, and other private and public payers. The current package no longer reflects the way that medicine is practiced; the access to care and protection from financial ruin promised by Medicare are being eroded by the costs of prescription drugs and potentially catastrophic levels of cost-sharing. While expanding benefits would likely increase program costs, broader benefits might also facilitate better management of chronic and long-term illness and disability, and reduce some of the inefficiencies associated with the current patchwork of supplemental insurance.

Medicare was originally designed as a social insurance program, rather than as a social welfare program. This means that the program is funded, at least in part, by mandatory contributions from wage-earners and / or employers, that benefits are paid from a fund earmarked for that purpose, and that Medicare pays out its benefits under the same set of rules for all qualified individuals participating in the program, regardless of health or economic circumstances. Program beneficiaries regard the health insurance they receive via Medicare as an earned right.

- In light of the risks Medicare was created to address — risks related to longevity, health, the structure of insurance and economic markets, and the unpredictability of the nature and costs of health care technology — social

insurance that spreads the risks of health care costs across generations remains the best, and in the Panel's view, the only politically feasible way to guarantee the health and economic security we as a society have promised to our fellow citizens, to our families, and to ourselves when we retire or become disabled.

- Proposals for securing the Medicare program for the future need to address what health care services Medicare will pay for, what mechanisms will determine how coverage and benefits will be adjusted to meet future circumstances, what portion of those costs can and should be borne by individual beneficiaries, and how the costs of care for those beneficiaries who cannot afford their share of payments will be allocated across other public programs, most importantly, Medicaid.
- Medicare's record in controlling costs has been no worse over time, and sometimes better, than that of the private sector. However, if Medicare is to be accountable to the public and to its beneficiaries, the Panel believes, it will have to do more to manage health care — as the private sector has tried to do — but with a much clearer focus on serving the needs of the beneficiary population, rather than just on cutting costs. This management would involve more active participation in efforts to determine what works well in medical care, which technologies are most effective, and how health care providers can be organized and paid to encourage efficiency and quality in the delivery of Medicare services. Medicare's appropriate role in managing the health care it pays for should be part of the debate about the future of the program.
- Medicare's other social roles are politically and socially important. However, such "public goods" as graduate medical education and support of disproportionate share and rural hospitals need to be addressed as separate public policy issues, rather than as part of the debate about the future of Medicare.

Decisions about Medicare's future, including its ability to deal with health care utilization and costs, will not (and cannot) be made on purely economic or medical criteria. Medicare has become part of America's infrastructure. It reflects deeply-held social and political values (including value conflicts), and reform policies must recognize these if they are to be successful.

- Medicare is a remarkably popular program, in large part because the public understands that the risks facing the Medicare-eligible population cannot be met in the private health care market at a price that most people can afford.
- The public cannot play a useful and meaningful role in the debate about the future of Medicare, and might, on the contrary, react in ways that could undermine needed reform unless concerted efforts are made to provide people with clear, usable information regarding the implications of reform, including how reforms will affect different individuals and population groups' health and economic security over time.

The Panel identified seven criteria for individuals to consider, and when necessary weigh against each other, as values and public policy concerns important in debating Medicare's future:

Financial Security *— The degree to which Medicare (under the current program or as reformed) can provide financial security to the elderly and disabled (and their families across generations) as they incur costs for medical care.*

Equity — *The degree to which Medicare is able to serve all populations fairly, including beneficiaries and future beneficiaries, regardless of age, health, gender, race, income, place of residence, and personal preferences.*

Efficiency — *The ability of Medicare to promote the use of appropriate and effective medical care for the beneficiary population, i.e. care that is technically efficient and minimizes the use of ineffective or unnecessary services, is consistent with the preferences of patients, and recognizes the real costs of services. Efficiency also includes the degree to which administration of the program is timely and responsive to the needs of consumers and providers, and the application of financing methods that are not unnecessarily burdensome.*

Affordability over time — *The degree to which the costs of Medicare can be borne without diverting public revenues needed for other important public priorities.*

Political accountability — *The degree to which the information needed to determine whether the program is achieving its goals is available, and mechanisms are in place to identify problems and institute corrective actions in a timely manner that is fair to all beneficiaries, to providers, and to taxpayers.*

Political sustainability — *The degree to which the Medicare program enjoys the support of the American population, regardless of the state of the economy, political climate, or social atmosphere.*

Maximizing individual liberty — *The extent to which Medicare policies, including incentives structured to promote efficiency, allow individual beneficiaries to exercise their own judgment and individual preferences in making choices about their health care.*

The report applies these criteria in its discussion of general reform options, including incremental changes such as increasing beneficiary cost sharing, raising the eligibility age, or expanding benefits or modernizing Medicare's administrative structure; and more fundamental restructuring options, including structured competition (with and without defined benefits) and individualized medical insurance.

None of the reform options currently being debated can increase the financial security of beneficiaries and simultaneously solve the problem of health care costs in an aging society. The evaluation criteria help identify the costs, benefits, and trade-offs of specific reform options. Among the most significant:

- Incremental reforms that increase beneficiary cost-sharing could undermine the basic financial protections Medicare was intended to provide; increasing revenues or reducing benefits also would not address the fundamental system-wide problem of health care costs, and how decisions about access and quality of care are to be made.
- Structured competition (including "premium support" models) and pre-funded individualized medical accounts would transfer some risk for health care costs from the government to individuals. In systems that do not provide for basic benefits defined in law, beneficiaries would have no assurance that they would be able to buy health insurance that provides the access to care and

protection against financial catastrophe that Medicare was created to provide.

- To enable beneficiaries to make good choices, and to be accountable to taxpayers, restructuring options that depend on the market to control health care costs may require new local, regional, and national information and oversight systems. This could increase, rather than decrease, government involvement in health care markets.

CONCLUDING OBSERVATIONS

The American people have accomplished a great deal by tackling problems of health care for the elderly through social insurance — including universal coverage, objective standards of qualification, no application of means tests, avoidance of financial destitution, creation of a sense of security and belonging, and acceptance of mutual obligations by the working population. Medicare has dignified the elder generation. It serves families of all ages: it is a promise to workers for their own retirement or disability, and a safeguard for young and middle-aged family members with sick or disabled grandparents or parents. The Panel observes, however, that the program's continued success may hinge on whether Medicare's benefit structure and administration can be reformed to take better account of the elderly population's health care needs and of the effects of health care costs on families' financial security across generations (including costs that might be borne by families if eligibility and benefits are restricted).

The specifics of reform policies, what they will cost, and how they can be paid for will be debated over the next few years. What needs to be made clear at this point in the debate is that decisions about Medicare's role in the American health care system and the implications of expanding, maintaining, or diminishing this role should be assessed carefully by policy makers and explained to the public before those changes are put in place. The Study Panel's final conclusion is quite simple: as we evaluate options for restructuring the Medicare program, we should remember what we have accomplished, and what we stand to lose as well as gain.

Chapter 1:
Medicare's Social Roles: Why it Was Created, How it Has Evolved, and Challenges for the Future

Medicare was established as a federal social insurance program because the private health care market failed to provide adequate, affordable health insurance to much of America's elderly population. In 1965, Congress recognized that few older people in the United States were free of the fear that costly illness could quickly exhaust their savings, and enacted the Medicare program to provide health insurance for people 65 years of age and older (U.S. Congress, March 29, 1965). This protection was expanded to people receiving Social Security Disability Insurance and people with serious kidney disease in 1972. One generation later a combination of factors — the imminent retirement of the Baby Boom generation, increasing health care costs and longevity, and technological advances in medical care (particularly those related to chronic conditions) that involve the use of services not covered by the current benefit package — has led Congress to revisit the social insurance program it established for older and disabled individuals. The Bipartisan Commission on the Future of Medicare, established in the Balanced Budget Act of 1997 (P.L. 105-33) was charged with making "comprehensive reform recommendations" to the President in 1999 (National Bipartisan Commission on the Future of Medicare, 1998).

Medicare has become a huge, complex program woven into the fabric of the American health care system. In this chapter, we first provide a brief overview of the origins and purpose of the Medicare program, then describe what the program does, both as an insurance program and as a vehicle for other aspects of public policy. The next sections of the chapter frame the problems facing Medicare and its present and future beneficiaries, drawing on comparisons to the health care systems in other industrialized nations. We then address specific aspects of the Medicare program and the American health care environment that are particularly important in the debate about Medicare's future.

WHY WAS MEDICARE ENACTED?

"As one of the 'elderly' as a widow, living on social security, I felt I must write to you. I have three daughters, who my husband and I were able to give a college education to by working endless hours in a small store — and by saving pennies bit by bit. We also saved to be independent when we grew older. One of our daughters has four children, one daughter has gone back to work to be able to be able to send her college age children to school, and one daughter is alone, and is working to support herself and her son. My husband and I carry hospital insurance —but he had a heart attack which forced him to give up work and which kept him in the hospital for 6 weeks — with the need for round-the-clock nursing care at $75 a day, and physicians' bill and medicines that cost over $2 a day. Our savings dwindled. Then came a disabling stroke, which again meant long hospitalization and

nursing care and medicines and payments for rehabilitation service. With good medical care we were able to prolong my husband's life, so he could take pleasure with his family, but my husband is now gone, and the $8,700 of our savings, My children, who have so many needs of their own — must help me meet the necessities of everyday living. Every bit of my life's work seems wasted, if I have to ask help of my children and if I become ill now—must I ask them to assume an even greater burden? I would have been so willing to pay for necessary medical coverage through a social security prepayment plan. Every parent wishes to pay his own way. Every parent wants to be able to be giving — not taking— we want to be independent, even if we are ill and old. We need the coverage that the Medicare bill provides.

— Mrs. M. Rawitch, Fairfield, Connecticut. Letter to the National Council of Senior Citizens, submitted to the House Committee on Ways & Means, 1964.

As America grew in affluence and science transformed the nature of health care after the end of World War II, not everyone shared the rewards. Summarizing the basic problem, Robert Myers wrote "persons aged 65 and older face health care costs that, on the average, are three times as high as for younger persons, while at the same time they have only half as much income." (Myers, 1970).

According to 1961 census figures, 45 percent of single individuals aged 65 or older had incomes of less than $1,000 per year, and two thirds had incomes of less than $1,500; (U.S. Congress, 1964). In 1964, the median income of family households headed by individuals over the age of 65 was $3,376 ($17,087 in real 1996 dollars), just over half of the median income for all families in that year ($6,569).[1] Hospital costs were rising faster than any other consumer items, with the average cost per patient day doubling from 1952 to 1962. Hospitalization rates were about twice as high for the elderly, and lengths of stay were about twice as long. The costs of health care were devastating for many elderly people. For those who required a hospital stay, the average cost was $700. The average price of comprehensive health insurance in the commercial market was estimated to be between $220 and $300 per person per year (for elderly couples, in the range of 13-20 percent of median income) in 1964. Elderly persons who rated their health as "poor" were half as likely to have insurance as those who rated their health as "good" (Blumenthal, Schlesinger, and Drumheller, 1988). There was also evidence that not having insurance kept people from obtaining hospital care: the National Health Survey and studies done by the Social Security Administration indicated that the rate of hospitalization for those who did have hospital insurance was about 14 percent per year, compared to between 8 and 9 percent of those without hospital insurance (U.S. Congress, 1964).

Most studies indicated that only about half of all elderly persons had health insurance in the mid 1960s, and many of these policies were not comprehensive, or were very expensive, or both. The private health insurance market was not working for elderly Americans:

1 $33,248 in real 1996 dollars.

government studies indicated that health insurance policies typically covered only one quarter of the hospital expenses for the elderly who did have insurance (Blumenthal, Schlesinger, and Drumheller, 1988). According to a study for the Senate Committee on Aging

> "only two-fifths of the insured aged have policies which will cover three-fourths of the hospital bill. The seniors pay more than younger people and receive less benefit…. Seventy percent of the people over age 65 with chronic conditions curtailing major activities do not have any type of health insurance. Sixty eight percent of people age 75 do not have any type of health insurance (U.S. Congress, 1964)."

According to the National Health Survey, "One fifth of the couples and 12 percent of the single people hospitalized each year indicated long-term debt resulting from their hospitalizations (U.S. Congress, 1964)."

The reasons for the low levels of insurance coverage were simple. An executive of the Health Insurance Plan of Greater New York summed up the problem from the perspective of retirees:

> "We have many enrollees who upon attainment of age 65 become ineligible to continue group enrollment and no longer have part or all of their premium paid by an employer or welfare fund. Two out of three of these people drop their health insurance. They simply cannot afford to go on at a time when their income is reduced, to pick up the full cost of health insurance which previously had been paid for all or in part by the employers. This is really tragic. (U.S. Congress, 1964)"

From the perspective of health insurance companies, the issues were also clear. The costs of covering the elderly population were too high. A spokesman for the nonprofit Blue Cross plans summed it up in a quote printed in the *Washington Post* on August 11, 1963:

> "Insuring everyone over 65 is a losing business that must be subsidized." (U.S. Congress, 1964).

WHAT IS THE MEDICARE PROGRAM?

Medicare was designed to provide a way for the nation's elderly and disabled populations to enjoy the health and financial security offered by private health insurance. As a program administered by the federal government and supported by mandatory contributions from workers and employers, and payments from program beneficiaries as well as general tax revenues, the program was structured as social insurance, based on principles we discuss in Chapter 2. The basic design of the insurance provided by Medicare represents the compromises made among competing points of view in 1965. The movement for government-organized hospital insurance for the elderly, which had gained momentum with the Forand bill of 1957 and subsequent legislative proposals, offered a conceptually clear-cut extension of the Social Security retirement program. Backed by organized labor among other constituencies, this method would raise the level of social security contributions paid by workers in order to pay for hospital and related nursing home and surgical services for retirees (seniors); but the proposals would not include health services unconnected with a hospital visit. This

policy thread was to be represented in Part A of Medicare in the 1965 legislation. Since private health insurance of the time was typically divided into hospital and medical insurance policies, the focus on hospitals followed the specialization of the private health insurance market.

A conceptually different approach was endorsed by the American Medical Association and others who objected strongly to the extension of social security into health care, for a variety of reasons, and instead proposed government subsidy to the private insurance system. The AMA's "Eldercare" proposal, for example, called for a federal-state program to subsidize private insurance policies for the elderly for hospital care, and also for doctor and pharmaceutical coverage. This policy thread was to be represented by Part B of Medicare, which provides voluntary, tax-supported "supplementary benefits" and requires participants to pay a monthly premium. (Workers and other taxpayers contribute to Part B through general taxation but not through defined Medicare contributions.) The third prong of the 1965 legislation, Medicaid, represented the views of those who felt that private health insurance should be used wherever possible, backed up by an extended medical welfare system. In the event, all these approaches were included in the 1965 legislation. From the beginning, the program was marked by complexity.

Medicare was modeled on the private insurance system in fundamentally important ways. The program was characterized by limitations on coverage to primarily acute-care and physician services, entirely separate provisions (i.e. different insurance programs — Parts A and B) covering hospital versus medical insurance (physician services, laboratory tests and other services), and, in comparison to government health care programs in many other industrialized nations, significant beneficiary cost-sharing. Medicare was designed to look and work like the insurance policies offered to the working population, and was to be operated by private sector insurance companies — "intermediaries" for Part A, and "carriers" for part B (Stevens, 1996; Brown, 1996; Blumenthal, Schlesinger, and Drumheller, 1988; Ball, 1998).

But from the beginning, Medicare was more than a means to provide the equivalent of private health insurance to the elderly. It took on larger social roles. Medicare was designed to be a new, reinforcing pylon in the private American health insurance system. Together with employment-based insurance and supplemental insurance, Medicare forms the foundations of an enormous, interdependent insurance system run (directly or via contract with the government) by the private sector that accounts for a large, and growing, proportion of America's gross domestic product (see below).

A second larger social role for Medicare was, from its inception, as a partner in a network of other public social insurance and social welfare programs, most importantly Medicaid, the nation's medical welfare program. Medicare cannot be fully understood without also considering its "conjoined twin." Established in the same statute (the Social Security Act Amendments of 1965, which incorporated Medicare as Title XVIII of the Social Security Act, Medicaid as Title XIX), Medicaid created a national program, administered by the states but funded jointly by the states and the federal government, to provide medical care to people living in

poverty, many of whom were elderly. From the beginning, Medicaid provided services to its enrollees that Medicare did not cover. Perhaps of most importance for Medicare policy today, those eligible for Medicare who deplete all their assets paying for long-term and chronic health care needs, and are thus impoverished, have been able to turn to Medicaid to cover long-term care. Together, the two programs have become the two largest health insurance programs in America. They pay for more than a third of all national personal health care expenditure (including one third of all inpatient hospital care and close to 30 percent of physicians' services) (U.S. DHHS, HCFA, 1996), and more than half of all the nursing home and home health care expenditures for people aged 65 or older in the United States (31.4 percent paid for by Medicaid, and 25.0 percent paid for by Medicare; (U.S. Congress, CBO, May 1998). In the discussion of Medicare's social roles in the health care system, its relationship to Medicaid is critically important: if controlling Medicare costs results in transferring costs to individuals who simply cannot pay, will Medicaid take on more of the burden, and with what effects on individuals, families, states, or the federal budget?

Medicare's other social roles include serving as a vehicle for providing specific subsidies to health care facilities, and as a major lever for broader social policy. Medicare funds are used to pay for graduate medical education, hospitals serving people without health insurance, and rural hospitals, and also to providing direct and indirect support for medical and health services research. More broadly, Medicare provides harder-to-measure economic and social support for working Americans who rely on the program to provide insurance to their parents and grandparents so that families, across generations, can remain financially independent. Medicare's role as a family program, crossing the paths of people of all ages, is an important element in its popularity (see Chapter 3). To understand how Medicare is performing all of its roles, we first review what the program is, how it has changed over time, and what problems it is facing now and over the longer term.

Medicare Part A and Part B Insurance

If policy makers were to design Medicare from scratch at the beginning of the 21st century, the basic design would be very different from the structure that has been pieced together from models derived from health insurance in the 1960s. In many ways, Medicare remains largely as it was when it was enacted.

The Medicare program currently consists of two parts, Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B), established in the 1965 legislation. The Hospital Insurance (HI) or Part A Trust Fund receives most (88 percent in 1997) of its revenues from a 2.9 percent tax on payroll (split evenly between employers and employees).[2] The HI Trust Fund represented about 66 percent of total Medicare

2 For single beneficiaries with taxable incomes above $34,000 and married beneficiaries with incomes above $44,000, some of the revenues from the taxes on a portion (up to 85 percent) of Social Security benefits are allocated to the Medicare HI Trust Fund as well as to the Social Security and Disability Insurance trust funds. In calendar year 1997, 3 percent of the HI Trust Fund revenues came from the benefits tax. Additional revenues come from interest earned by investment of the trust fund (8 percent of revenues in 1997), and miscellaneous sources such as gifts and receipts from fraud and abuse control efforts (The Board of the Trustees, OASI and DI, 1998).

expenditures in 1997. In contrast, the Supplementary Medical Insurance (SMI) or Part B Trust Fund receives 75 percent of its funds from general federal tax revenues and almost all of the rest from premiums paid by beneficiaries ($45.50 per month for enrollees in 1999). Part A coverage is automatic for those who are eligible (see below). Part A pays for inpatient hospital care, skilled nursing facility care, home-health care associated with a covered hospital or nursing home stay, and hospice care, but the coverage is not comprehensive. Coverage for part A services is subject to limits on the number of days covered. For hospital care, the most expensive service, Medicare covers services for up to 90 days in a "spell of illness" plus a lifetime reserve of 60 days. In 1999, beneficiaries pay an initial deductible ($768) and a coinsurance of $192 per day for hospital days 61 through 90, and $384 per day for lifetime reserve days. There is a 100 day limit on covered skilled nursing home stays under Medicare Part A, with a coinsurance rate (applied to days 21-100) of $96.00.

Participation in Part B is voluntary for eligible individuals,[3] who pay a monthly premium of $45.50 (in 1999) and a deductible of $100 per year. However almost all (over 95 percent) of persons enrolled in Medicare Part A also choose to enroll in Part B. It covers physician services (including office visits, surgeries, and consultations); outpatient services at hospitals; lab and other diagnostic tests and specified screening tests; and mental health services; home health services not covered under Part A; certain other medical services such as ambulance services, physical therapy, speech therapy and occupational therapy, and certain medical appliances and durable medical equipment; and diabetes outpatient self-management training. Beneficiaries are generally responsible for paying 20 percent of the recognized charges for provider charges billed under Part B (plus balance billing),[4] but there are special provisions relating to charges for blood, special limits on certain charges for mental health services, and a variety of other limits and adjustments. There is no beneficiary coinsurance payment for home health services, covered vaccinations or immunizations, or outpatient clinical laboratory tests, but there is a co-payment for x-rays, electrocardiograms, and computerized imaging tests.

With the exception of individual services specified in law, Medicare does not cover outpatient prescription or over-the-counter drugs, except for those provided as part of covered Part A hospital, skilled nursing home or hospice benefits. Medicare does not cover most immunizations or vaccinations, dental

3 To be eligible for Part B, individuals must be eligible for Part A, or be eligible as citizens or persons lawfully admitted for permanent residence with at least five consecutive years of residence (except subversives) (Myers, 1998).

4 Physicians who do not agree to accept Medicare fee schedule payments as the full payment (but who do accept Medicare insurance payments) may bill up to 115 percent of the approved Medicare payment, which, for "non-participating" physicians, is 95 percent of the normal Medicare payment. Beneficiaries may therefore be responsible for paying the balance bill amount, which is the difference between 80 percent of the Medicare payment amount (paid by Medicare) and up to 109.25 percent (115 percent of 95 percent) for Medicare Part B bills. The private physician contracting provisions of the Balanced Budget Act of 1997 allowed beneficiaries and physicians to enter into private contracts in which there are no balance billing limits; under the provisions of the bill, physicians engaging in private contracting would not participate in the regular Medicare program for two years.

services, routine physical exams, hearing or eye exams, eyeglasses or contact lenses or hearing aids, elective cosmetic surgery, or custodial or other private, family-supplied nursing services, or long-term care in nursing homes. Some but not all of these can be covered by various forms of supplemental insurance, which we describe below.

Eligibility and Enrollment

Persons are eligible for Medicare if they (or their spouses) have at least 40 quarters of coverage (through employment), are at least 65 years old, and are citizens or permanent residents of the United States. Younger individuals can qualify for Medicare if they have worked sufficient time in Medicare-covered jobs and they have received Social Security Disability Insurance (DI) benefits for two years or if they have dialysis-dependent end-stage renal disease (ESRD). Persons who do not have sufficient work history to qualify can still purchase Medicare by paying an actuarially fair premium if they are over 65 or have ESRD, and persons who have become ineligible for disability benefits because they have returned to work can also voluntarily enroll. Some individuals, such as people who did not work in jobs in which they or their employers paid Medicare payroll taxes, or people who have not lived in the United States long enough to have worked for 40 quarters enroll in Medicare by paying (or having a former employer pay) a premium equal to the full actuarial value of the program's coverage.[5] In 1998, about 22,500 people "bought into" Medicare under these provisions (Diacogiannis, 1999). As discussed below, states can also pay for Medicare cost-sharing (including Part B and or Part A and B premiums, deductibles and copayments; see below) for low income individuals. In the first quarter of fiscal year 1999, there were about 340,000 enrollees participating through these state buy-in arrangements for Part A and 5.2 million for Part B (Higger, 1999).

The number of individuals enrolled in Medicare has doubled since its inception, growing from 19.5 million persons in 1967 to 38.6 million, or about 14 percent of the total population, in 1997 (U.S. DHHS, HCFA, December 31, 1997). This growth reflects a lengthening life span for Americans, and other factors that have increased the over-65 population, as well as the decision to cover people with permanent disabilities and kidney disease, and otherwise non-covered persons who elect to buy into the program. The fastest rate of enrollment in Medicare has been among those with ESRD and people with disabilities, who comprised about 13 percent of program enrollees (4.8 million people) in 1997 (U.S. DHHS, HCFA, 1998). By 2022, Medicare is projected to cover 64 million (22 percent of the population), rising most dramatically after the Baby Boom generation begins to retire in 2010 (Appendix A figure 1-1) (U.S. Congress, CBO, 1996; U.S. Congress, CBO, May 1998). As shown in Appendix A table 1-1, Medicare's current beneficiaries are predominately under 75 years old (59 percent), female (59 percent), white (85 percent), and urban (73 percent). As the Medicare population as a whole grows, so too will the number of very old beneficiaries. Those over 85 years old are expected to grow significantly as a

5 In 1999, the full monthly Part A premium for individuals buying Medicare coverage is $309; the Part B premium for all enrollees is $45.50.

proportion of beneficiaries, from 3.8 million in 1997 to 8.5 million in 2030 (Day, 1996).

WHAT DOES MEDICARE BUY?

Medicare is health insurance that pays mostly for acute and post-acute health care services provided by hospitals, physicians, and nursing homes, home health agencies, rehabilitation centers, and hospice programs. Over time, it has become the biggest single purchaser of health care in the United States.

Total Spending

As a society, we have spent increasing amounts of money on health care in the United States. Between 1960 and 1996, total personal health care expenditures (PHCE)[6] rose from $127 billion in real 1996 dollars (4.6 percent of gross domestic product (GDP), a measure of all domestic spending in the economy) to $907 billion (11.8 percent of GDP) (Appendix A figure 1-2). PHCE *per capita* in 1996 were over 5 times greater than they were in real terms in 1960. Medicare is a significant, but not the only contributor to the growth in national health care expenditures. Health care spending was growing rapidly before Medicare was enacted, and since the program was established, Medicare and PHCE have grown in tandem. As illustrated in Exhibit 1, over different periods of time, Medicare costs grew at a slower rate. At other times, Medicare costs grew more rapidly than total PHCE.

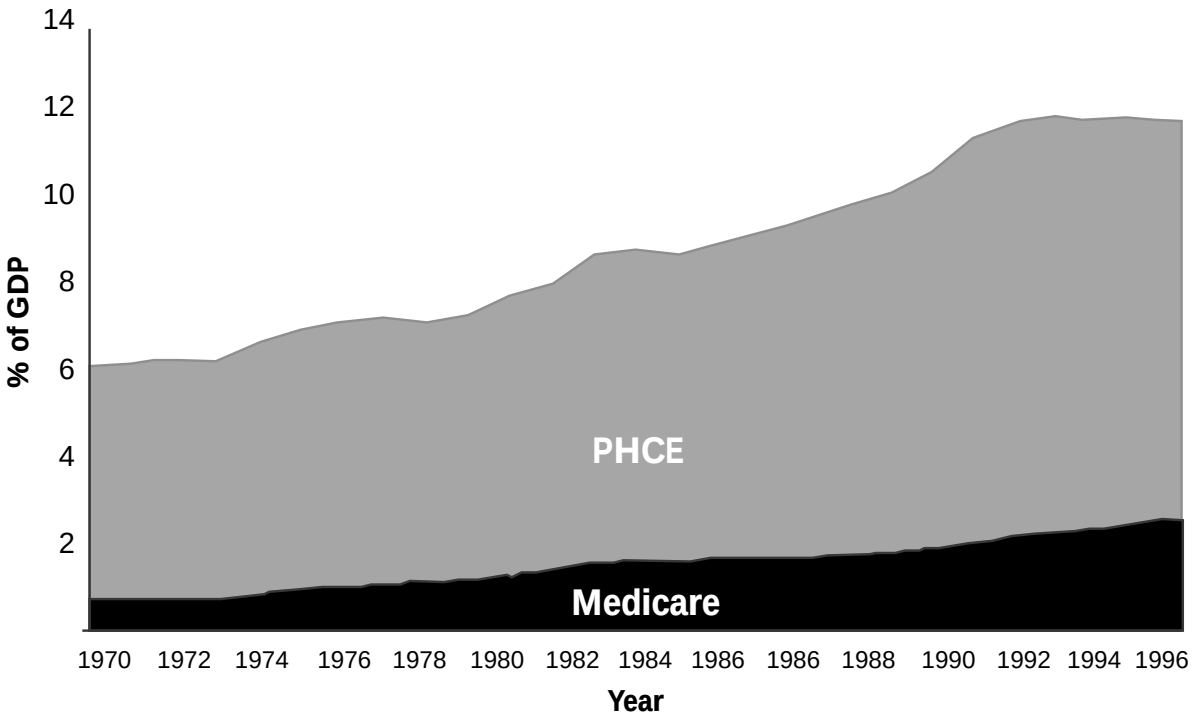
Medicare spending reflects both the growth in the covered population (including the inclusion of disabled beneficiaries beginning in 1972 as well as the aging of the population) and increases in health care spending per enrollee. In real terms (1996 dollars), Medicare program spending increased from $29.5 billion in spending in 1970 (using 1970 as a point by which Medicare and its administrative reporting systems were fully in place) to $198 billion in 1996 (Appendix A figure 1-3). Medicare expenditures grew faster than overall health care expenditures during this period. Medicare spending in 1996 was more than 6 times higher, in real terms, than in 1970, while total spending on personal health care services grew less than four-fold over the same period. Medicare expenditures in 1997 were estimated to be $207 billion (U.S. Congress, CBO, May 1998). As a share of all PHCE, Medicare spending almost doubled during this period, growing from 11.4 percent to 21.8 percent. As a share of GDP between 1970 and 1996, Medicare grew more than three-fold, from less than 1 percent to 2.6 percent (Appendix A figure 1-4).

In addition to general inflation and increased numbers of beneficiaries, economists usually credit the dramatic rise in Medicare spending to the rise in health care costs which stem from technological advances in medicine that have resulted in a larger number of more costly services provided to patients. As we discuss below, Medicare's reimbursement system, like other fee-for-service (FFS) insurance, created incentives to use as many medical services, tests and procedures as practitioners and / or patients believe are appropriate or possibly beneficial. Medicare made access to state-of-the art technology possible for the large proportion of elderly and disabled Americans who could not afford private insurance to pay for it.

6 PHCE include all spending for health care except construction, program administration, government public health activities, and research (U.S. DHHS, HCFA, 1997).

Exhibit 1

Personal Health Care Expenditures (PHCE) and Medicare Expenditures as a Percentage of GDP



Source: National Academy of Social Insurance, based on data from HCFA (Office of the Actuary) and the Department of Commerce (Bureau of Economic Analysis), 1998.

As expenditures and the number of Medicare beneficiaries increase, the Medicare HI Trust Fund is being depleted. Under what they termed their "intermediate" or "best guess" assumptions in 1998,[7] the Trustees projected that the HI Trust Fund would be exhausted in 2008 (The Board of Trustees, HI, 1998) (Exhibit 2)

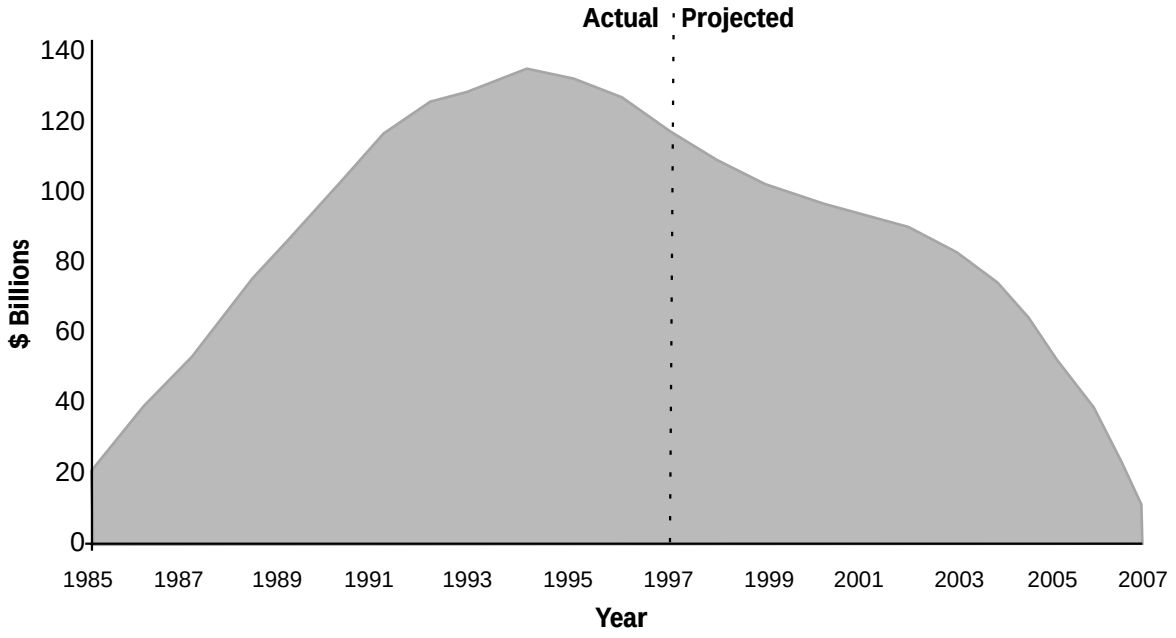
Changes in the economy and in the rate of change in health care expenditures could affect the rate at which the HI Trust Fund is depleted, but it seems clear that without changes in the revenue flow to the fund, or in the rate of fund outlays, Medicare will not be able to pay for the next generation of Medicare beneficiaries' Part A insurance claims. Not surprisingly, the policy focus on Medicare has been directed at its costs, rather than on its value to the American population.

Understanding the relative importance of the factors that have contributed to increases in Medicare spending is centrally important in framing the debate about the future of the program. A significant body of evidence suggests that while the larger number of beneficiaries (who are living longer), and general inflation in medical costs are important factors in increased Medicare spending; *the*

7 The 1998 Trustees report intermediate assumptions included an estimate of 3.5 percent annual change in the consumer price index and a real interest rate of 2.8 percent.

Exhibit 2

Medicare Hospital Insurance (HI) Trust Fund End-of-Year Balance, Calendar Years 1985-2007



Note: Using intermediate assumptions, Trustees of the HI Trust Fund project that it will be exhausted in 2008 without changes to reduce costs or increase revenues.

Source: National Academy of Social Insurance, based on data from the *1998 Annual Report of the Board of Trustees of the Federal Hospital Insurance Fund*, p. 38-39, Table II.D2.

increase in real per-enrollee costs is the most important determinant of program cost increases. In short, Medicare is spending more, in real terms, on an average beneficiary year-by-year. The average amount spent on each Medicare beneficiary rose, in constant 1996 dollars (i.e. controlling for inflation in medical care costs), from $1,735 to $5,245 (202 percent) between 1975 and 1996 (U.S. Congress, Green Book, November 1996) (Appendix A figure 1-5). Per capita health care costs have increased for the entire American population, but, because actual health care costs are on average significantly higher for the elderly and disabled persons, per capita cost increases are in effect amplified in the Medicare program. The volume and intensity of health care services provided in both Medicare and Medicaid are projected to rise faster than the Gross Domestic Product (GDP), thereby placing significant pressure on the Medicare HI Trust Fund — and on the entire national budget (U.S. Congress, CBO, May 1998). In the words of a leading health economist, Victor Fuchs,

> "[T]he increase in health care expenditures for persons 65 and over is ***not*** primarily a demographic phenomenon… There has been and will continue to be some growth in the number of elderly,

but more than two-thirds of expenditure growth has come from an increase in age-specific expenditures. Why did older persons use so much more health care in 1995 than in 1975 or 1985? Certainly not because they were sicker in 1995. On the contrary, most experts believe that the elderly are healthier than at any previous time…

There is substantial consensus among health care experts that the driving force behind increasing health expenditures is new technology — new methods of drugs, new surgical procedures, and the like. (Fuchs, 1998)."

What Medicare is buying for beneficiaries is an increasingly complex package of services that is constantly evolving, and virtually impossible to anticipate, particularly for the longer term. The "necessary and appropriate" acute care services that Medicare pays for has changed remarkably since 1965, and will continue to change, transforming the lives of uncounted beneficiaries. Some groups within the beneficiary population have seen particularly striking changes, raising questions of equity that could not be anticipated when the program was established. For example, major surgery is now as available for the very old as it is for younger people. One sixth of all hospital inpatient surgery is for individuals age 75 or older (National Center for Health Statistics, 1998). Should the United States accept rationing of services by age to control per capita health care spending? In framing the issues in Medicare reform, therefore, we need to consider how these services are being used. Is it possible to devise systems than can control the future growth in the volume and intensity of health care services in ways that are morally, politically and socially acceptable?

Variations in Spending

In addition to understanding what is driving health care costs, it is important to understand how spending is distributed throughout the population. Although Medicare's financing structure and benefit package are uniform across the country, spending varies substantially across types of beneficiaries and geographic areas (as it does in the private insurance market). As shown in Appendix A table 1-2, Medicare spending per beneficiary is highest for enrollees with end-stage renal disease (ESRD). For those 65 and older, the average payment per beneficiary increases with age. Spending per beneficiary is higher for whites than non-whites. However these figures are dramatically reversed when examining average spending for each beneficiary who actually used services ($5,016 for whites and $7,369 for non-whites in calendar year 1995) (U.S. DHHS, HCFA, 1997).[8] Non-white Medicare beneficiaries who do seek medical care may have substantially greater health needs, but they are, as a group, less likely to receive — and perhaps to seek — any Medicare service (Gornick, et al., 1996). A consistent body of research has found that, for non-white populations, being enrolled in Medicare does not automatically translate into obtaining needed care (see below).

Average spending per beneficiary also varies substantially around the country, with the Midwest having the lowest costs and the northeast having the highest. Costs in urban areas exceed those in rural areas throughout

8 For all other breakdowns in Appendix A table 1-1, differences in average spending per beneficiary parallel differences in spending per beneficiary actually using Medicare services. See Table 14 in US DHHS, 1997b.

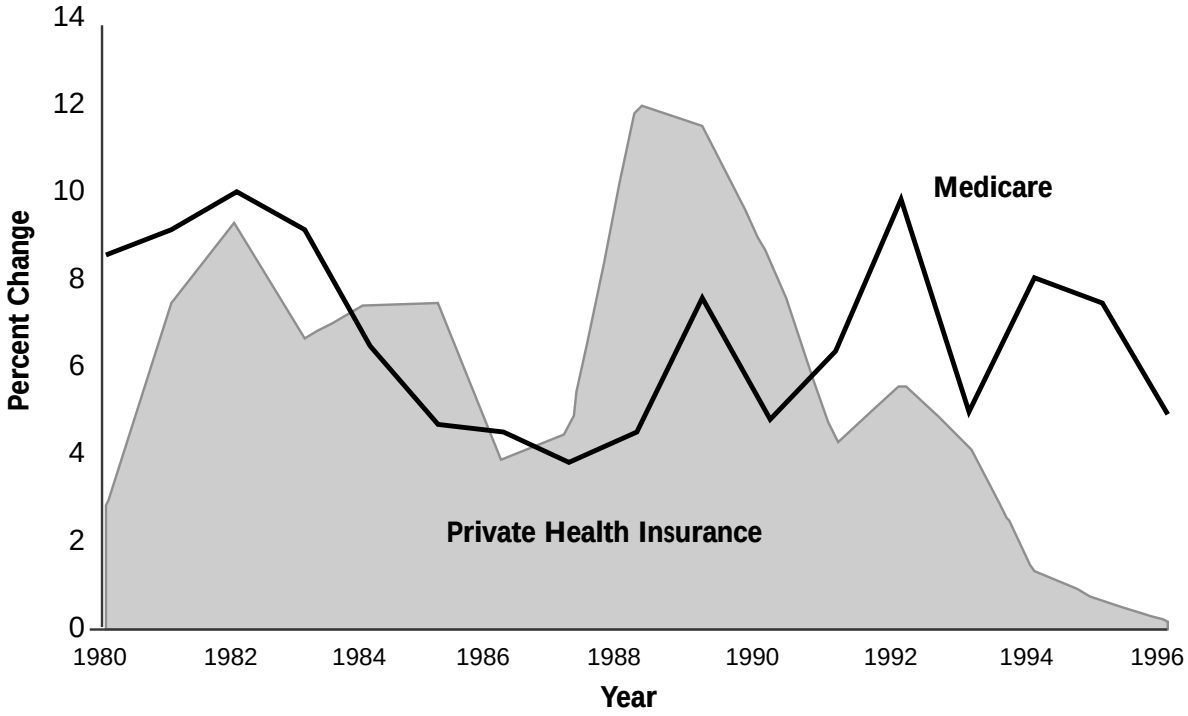
the country (see Appendix A table 1-2). Some of the variations in average Medicare spending per beneficiary are quite disturbing. In Hennepin County, Minnesota (Minneapolis), the monthly capitation rate (paid to Medicare HMOs for each enrollee) for beneficiaries age 65 and older — which is set using a formula that reflects per capita costs for Medicare beneficiaries in the fee-for-service program — is about $420 in 1999; in Dade County, Florida (Miami) the monthly capitation rate is about $780. Rates throughout Florida, with the exception of one rural county that receives the minimum national rate, are higher than in almost every county in Minnesota. These rates illustrate a very different pattern of service use and local market prices for health care services in these two states. Research over the last twenty years has shown that geographic variation in the practice of medicine is not explained by patients' underlying health needs, and that higher rates of service utilization do not necessarily result in better health outcomes for patients. But the variations do not appear to be associated with clearly "inappropriate" or unnecessary use of services either. Rather, the variations appear to result from intangible factors, like "practice style" which may reflect uncertainty or lack of scientific evidence about what actually constitutes the "best" practice. Differences in practitioner education and training and variations in the organization and availability of local health care resources also appear to play a part (U.S. Congress, OTA, September 1994; Dartmouth Atlas of Health Care, 1998). Regional variations have become a focal point for policy makers because of the saving that might be obtained if the factors that lead to more efficient (and less costly) health care delivery in some regions can be identified and put into practice in less efficient areas. How this sort of "technology transfer" or "behavior change" can be achieved raises important questions about local versus national standards for health care, and about the appropriate role of Medicare, as a national program, in setting performance standards for health care.

Market variations in the use and cost of health care are characteristic of the entire health care system, not just Medicare. There are significant differences in cost structures across regions and local market areas (Dartmouth Atlas, 1997). A policy relevant question for Medicare is whether its reimbursement mechanisms and administrative systems have amplified existing market variations, or otherwise undermined the program's ability to control costs relative to the private sector, which has far more ability to adapt to local market conditions. One way to address this question is to compare the rate of growth in Medicare to the rate of growth in what private health care spends per enrollee.

Exhibit 3 suggests that from 1980 through 1996, Medicare's record has been neither consistently better nor worse than that of the private sector when it comes to controlling health care costs. In some periods, Medicare has done relatively better, most likely as a result of payment reforms such as prospective payment for hospitals in the 1980s and the introduction of the physician payment reforms in the early 1990s (MedPAC, July 1998). A model developed by the Office of the Actuary, HCFA, for the period 2001-2007 predicts that limitations on provider payment introduced by the Balanced Budget Act of 1997, along with the expansion of managed care enrollment in Medicare, could help slow the rate of growth to levels *lower*

Exhibit 3

Real Change in Per-Enrollee Medicare and Private Health Insurance Spending, 1980-1996 (In Percent)



Note: Real spending is adjusted by the consumer price index for all urban consumers (CPI-U-X1). Spending includes personal health care plus program administration or net cost of private health insurance.

Source: *Health Care Spending and the Medicare Program: A Data Book*, Medicare Payment Advisory Commission, July 1998, p. 8, Chart 1-7.

than in the private sector (Smith, et al., 1998). In other periods, including the mid-1990s, private employers were more successful controlling costs, most recently by inducing more employees to enroll in managed care (MedPAC, July 1998). There is some evidence that there are spillovers from one sector to the other: Medicare payment reforms can shift some costs to the private sector, but the adoption of Medicare payment reforms by the private sector may also drive down costs (Moon, 1993; Carter, et al., 1994; McCormack and Burge, 1994). As managed care systems play a larger role in local markets, the overall practice patterns of providers may change; more efficient practice patterns could help control costs for all payers, including Medicare (Chernew, et al., 1998). The records of both private sector insurers and Medicare suggest that, for better or worse, the original legislative intent — that Medicare not dominate or substantially interfere with or constrain the private health care system or insurance markets — was largely achieved. At the same time, the evidence seems to indicate that neither the private nor public sector has found effective,

enduring administrative or market solutions to the cost problem.

Gaps in Medicare Coverage

Ironically, the other Medicare problem, in addition to program costs, is that Medicare's benefits package has not kept up with the benefits offered in the employer-sponsored health insurance market. A 1998 study comparing Medicare with a sample of 250 employer plans offering indemnity-type benefits (traditional insurance) found that 82 percent of the plans offered more comprehensive benefits than Medicare (McArdle and Yamamoto, 1998). Because Medicare includes significant cost-sharing by beneficiaries and excludes outpatient prescription drug coverage and other services, most beneficiaries must pay some health care expenses out-of-pocket. For many beneficiaries, these amounts are substantial. Excluding home health care and nursing facility costs, the average beneficiary spent $2,149 out-of-pocket in 1997; on average, this represented 19 percent of beneficiaries' income (Appendix A table 1-3).

Beneficiaries' out-of-pocket expenses include health insurance premiums as well as direct spending on health care services. Appendix A table 1-4 shows the composition of out-of-pocket spending for three groups of beneficiaries over 65 years old — those who have private supplemental insurance that they purchase themselves or through a former employer, those enrolled in fee-for-service Medicare who do not have other private insurance or Medicaid coverage, and those enrolled in a Medicare HMO (AARP PPI and the Lewin Group, 1997). Total out-of-pocket spending is higher for beneficiaries who buy private insurance to supplement Medicare, but those relying solely on Medicare coverage spend more of their own money on hospital and doctor bills. Premiums for private insurance represent the single largest expense for those who have such coverage. Total out-of-pocket spending is similar for HMO enrollees and those with Medicare coverage only, but HMO enrollees have more covered benefits than the Medicare-only group and lower out-of-pocket spending on direct health services than either of the other two groups.

In 1997, based on a model developed by The Lewin Group, Inc., about 14 percent of non-institutionalized beneficiaries age 65 or older relied solely on Medicare for health insurance coverage. Most beneficiaries had some form of private supplemental coverage in addition to Medicare; 33 percent had additional coverage sponsored by an employer, and 28 percent purchased an individual private (Medigap) policy. Thirteen percent were enrolled in Medicare HMOs and 12 percent were enrolled in Medicaid at least part of the year (Gross, et al., 1998).

However, in the private Medicare supplemental market, premiums for older beneficiaries are rising rapidly, and there has also been an increase in the proportion of supplemental policies that rate by age, i.e. charge older beneficiaries more. Recent analyses also indicate that few supplemental insurance carriers are offering policies to Medicare beneficiaries with chronic health care conditions, and those carriers that do guarantee coverage to all are raising their premiums (Alecxih, July 14, 1998). At the same time, employers are cutting back on the provision of group-based supplemental insurance for retirees. Fewer employers are offering these retiree benefits, and of those that do provide supplemental insurance, more are limiting the choices of

supplemental plan (often by requiring that retirees enroll in some form of managed care to be eligible for an employer-financed supplement), and more employers are requiring that employees pay more toward the premiums and / or more in deductibles or copayments (U.S. Congress, GAO, June 1998).

For a growing number of Medicare beneficiaries (close to 14 percent), managed care has provided an alternative means of getting help with the costs of deductibles, copayments and uncovered services. Under Medicare's managed care options, health care plans agree to provide Medicare-covered services to enrollees in return for a fixed rate of payment from Medicare for each enrollee (a "capitation rate"). Medicare law establishes how the capitation rate is set for each Medicare enrollee who chooses to join a Medicare managed care plan, based on a variety of factors including Medicare costs in the area, beneficiary age and sex, and whether the beneficiary is institutionalized. The beneficiary's monthly Medicare Part B premium set in law makes up part of the payment, and Medicare pays the rest (the average monthly payment to managed care organizations for all beneficiaries aged 65 or more was $467 in 1997, $400 for disabled beneficiaries).

Currently, almost all Medicare health plans paid under capitation arrangements offer some benefits beyond those covered under standard Medicare fee-for-service insurance. Most provide routine physical examinations, eye and hearing exams, immunizations, and some sort of coverage for outpatient prescription drugs. Many of the plans offering these benefits do so without charging any additional premium for the enhanced benefits (MedPAC, July 1998). One reason that plans offer these benefits, however, is that the payment mechanism that was in place until the passage of the Balanced Budget Act of 1997 tended to overpay plans in many parts of the United States. The payment methodology, which was designed to reflect local average per-beneficiary Medicare expenditures, often resulted in payments to plans that far exceeded the costs of providing the covered benefits for those who actually enrolled. If a plan's expected revenues exceed costs (plus allowable profits), it is required to return the excess "savings" to the government, or use it to provide additional benefits to enrollees. Plans have therefore been able to provide supplemental benefits without passing the costs on to beneficiaries. These benefits are highly valued by enrollees, and help plans recruit new enrollees.

If payment reforms succeed in eliminating the overpayment to plans, the extra benefits may be withdrawn. By late 1998, more than 40 Medicare capitated "risk" plans had decided not to renew their contracts with the Health Care Financing Administration (HCFA) to provide Medicare benefits, and another 52 announced plans to reduce their service areas. This could create serious problems for beneficiaries who cannot find another HMO in which to enroll, and who cannot afford to buy Medigap insurance.[9] As the first open enrollment period for the Medicare plans options established under the Balanced Budget Act approached in the fall of 1998, the reductions in service by HMOs were esti-

9 The Medicare provisions of the Balanced Budget Act of 1997 (P.L. 105-33) provide some protection to beneficiaries age 65 or more. The provisions are complicated, but, in general, the legislation guarantees access to certain Medigap policies for elderly beneficiaries who 1) lose supplemental coverage because their employer-provided policies are discontinued, 2) are dropped from coverage they had through the discontinuation of a

mated to affect about 415,000 beneficiaries in 371 counties nationwide, about one third of these in rural areas.[10] At the same time, however, there were 48 new applications under review for Medicare+Choice plans (43 Health Maintenance Organizations, four Provider-Sponsored Organizations, and one Preferred provider Organization). It is not yet clear to what extent managed care will be able to provide the additional insurance that beneficiaries seek; nor how many beneficiaries would choose to enroll in managed care if the additional benefits were not offered.

As Medicare cost-sharing increases, Medicaid is assuming a growing role in protecting Medicare beneficiaries. Analysis by the Lewin Group shows that of all Medicare beneficiaries receiving some supplemental coverage through Medicaid in 1997, more than half qualified for full Medicaid benefits, which cover Medicare premiums, copayment and deductibles, and for other Medicaid benefits that are not covered under Medicare, such as prescription drugs, dental care, eye care, and routine physical exams (Alecxih, July 14, 1998). Most of the rest qualified under the provisions called the Qualified Medicare Beneficiary program (QMB), which is available to Medicare beneficiaries with incomes below the poverty line who do not qualify for Medicaid. The QMB program pays for Medicare premiums, copayments and deductibles. Medicaid also provides some supplemental coverage to three other groups of low income individuals:

- *Specified low income Medicare beneficiaries (SLMBs)* are individuals with incomes under 120 percent of the poverty level; they are eligible to have Medicaid pay their Medicare premiums
- qualifying individuals (called *QI-1's*) are individuals who have incomes of less than 135 percent of the poverty level. They may apply to Medicaid to have their Medicare premiums paid, and
- a second category of qualifying individuals (called *QI-2's*) includes individuals with incomes that are below 175 percent of the poverty line. These individuals can apply to Medicaid to pay for a portion of their Medicare premium that is the result of a shift in program costs for most home health services from Part A to Part B by the 1997 Balanced Budget Act.

Medicaid will cover all QMBs and SLMBs who apply for the benefit and meet the requirements. Recent estimates are that less than 60 percent of the approximately 8 million beneficiaries eligible for QMB or SLMB buy-ins are actually receiving this supplemental benefit. Annual funding for the QI's is capped, so that only those who apply before the funds appropriated for the program are expended can receive the additional coverage. In its first year (1998), however, enrollment

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demonstration, or 3) lose coverage because of the failure of a supplemental carrier through insolvency or bankruptcy. Beneficiaries under the age of 65 (those eligible due to disability) are not covered by the guaranteed issue provisions. Beneficiaries who enroll in Medicare+Choice health plans when they turn 65 then disenroll from the plan within 12 months are provided with guaranteed issue protection for supplemental insurance, but individuals who voluntarily drop Medigap coverage after continuous enrollment in an HMO for more than 12 months are not provided any guaranteed issue protection if they return to fee-for-service. Guaranteed issue does not, moreover, prevent insurers from charging high premiums to persons considered to be at risk of high medical costs.

10 HCFA estimated these service reductions affected about seven percent of all beneficiaries, but that less than one percent would be left with no managed care option available (U.S. DHHS, HCFA, October 10, 1998)

in the QI programs was extremely low, with less than 5000 of the 1.6 million people estimated to be eligible for the benefits actually signed up. Funding levels for 1997 would have allowed 500,000 QI buy-ins (Families USA, 1998).

A significant number of Medicare-eligible persons also obtain some or all of their care through the Department of Veterans Affairs (VA) health programs.[11] Some of these individuals use VA medical services as a form of supplemental insurance, most often for obtaining prescription drugs (U.S. Congress, GAO, October 1994). Those in the VA system also have access to dental care, audiology and optometry services, limited deductibles and cost sharing on medical services, and no caps on the number of days of psychiatric care for covered conditions.

MEDICARE'S ECONOMIC IMPACT ON FAMILIES

To what extent does Medicare contribute toward the economic security of its beneficiaries and their families? Most Medicare beneficiaries are retired and live on limited incomes.

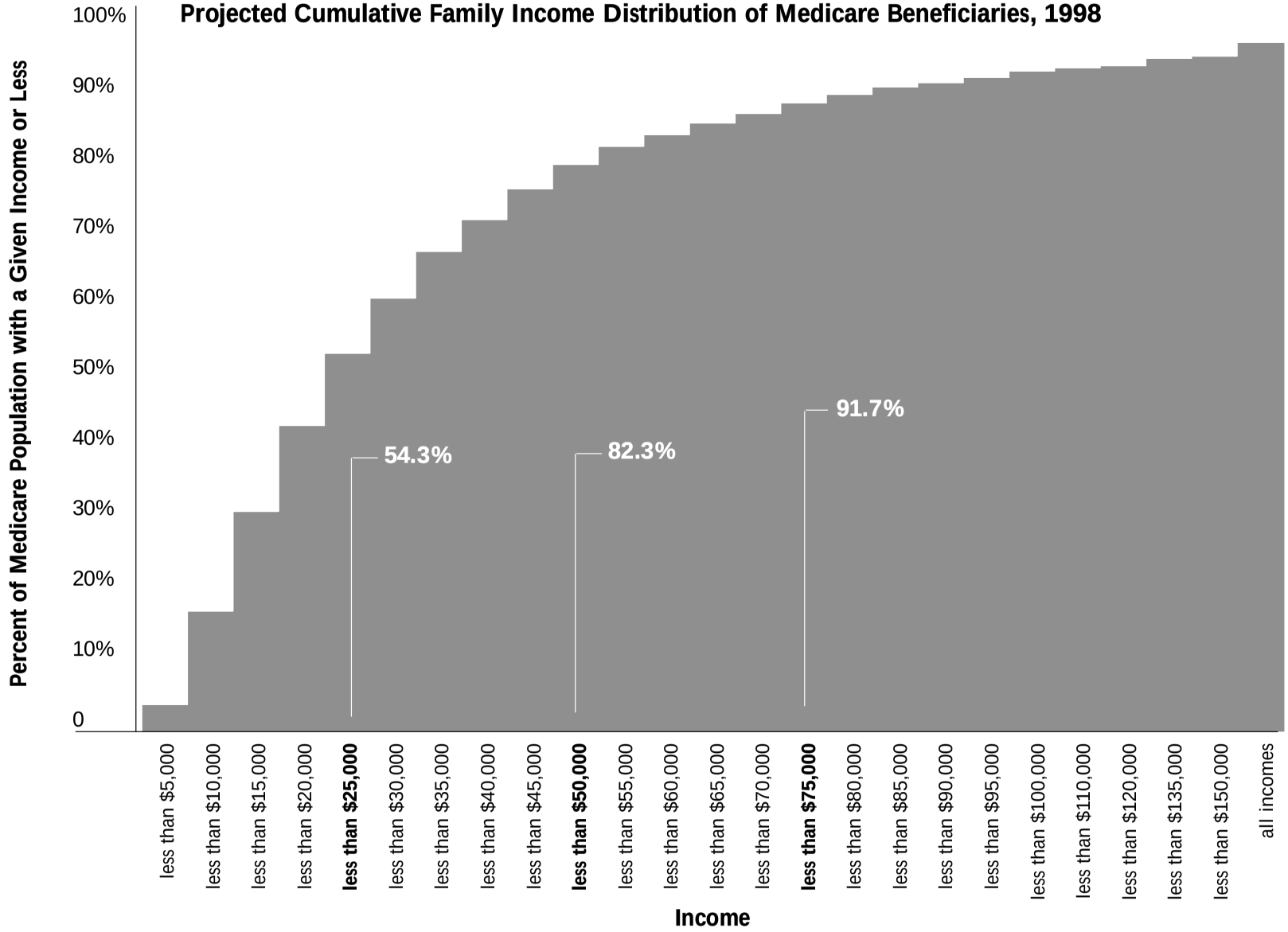
Exhibit 4 shows the cumulative distribution of beneficiaries' total family incomes; i.e. for any given income level, it shows the percentage of beneficiaries who have family incomes of that amount or less. Appendix A figure 1-7 shows the distribution of income. In 1997, federally-defined poverty levels for persons over age 65 were $7,755 for individuals and $9,780 for couples (AARP PPI and the Lewin Group, 1997). Almost a third of Medicare enrollees were estimated to have had 1998 incomes less than $15,000, more than half less than $25,000, and 70 percent less than $30,000. About 10 percent of beneficiaries had a family income of over $75,000 per year, and about 5 percent had family incomes of over $100,000 (Exhibit 4).

Appendix A figure 1-8 shows the sources of family income for persons age 65 and older in 1996. The majority depend on Social Security for the bulk of their income, with public assistance providing a significant portion for the poorest. As income rises, so too does the portion of income from earnings and assets. However, even among the top quintile, Social Security accounts for 41 percent of income. Many beneficiaries are acutely aware of the link between the two programs; an increase in Medicare premiums reduces the size of monthly Social Security checks, and if Social Security increases do not keep up with Medicare cost-sharing, the premiums and coinsurance become a greater burden.

Lower income Medicare beneficiaries also spend larger portions of their income on health costs than do higher income beneficiaries. As shown in Exhibit 5, those beneficiaries below the poverty level spend, on average, more than a third (35 percent) of their incomes on health-care. In comparison, beneficiaries with the highest incomes (more than 400 percent of the poverty level or

11 A study conducted by the General Accounting Office in 1994 assessed the use of Medicare services for about 4.4 million veterans who were eligible for Medicare. That study found that 490,000 used VA facilities exclusively, 2,500,000 used only Medicare, 564,000 used both VA and Medicare services, and 861,000 did not use either Medicare or VA services in 1990, the last year for which data were available for analysis (U.S. Congress, GAO, April 25, 1994).

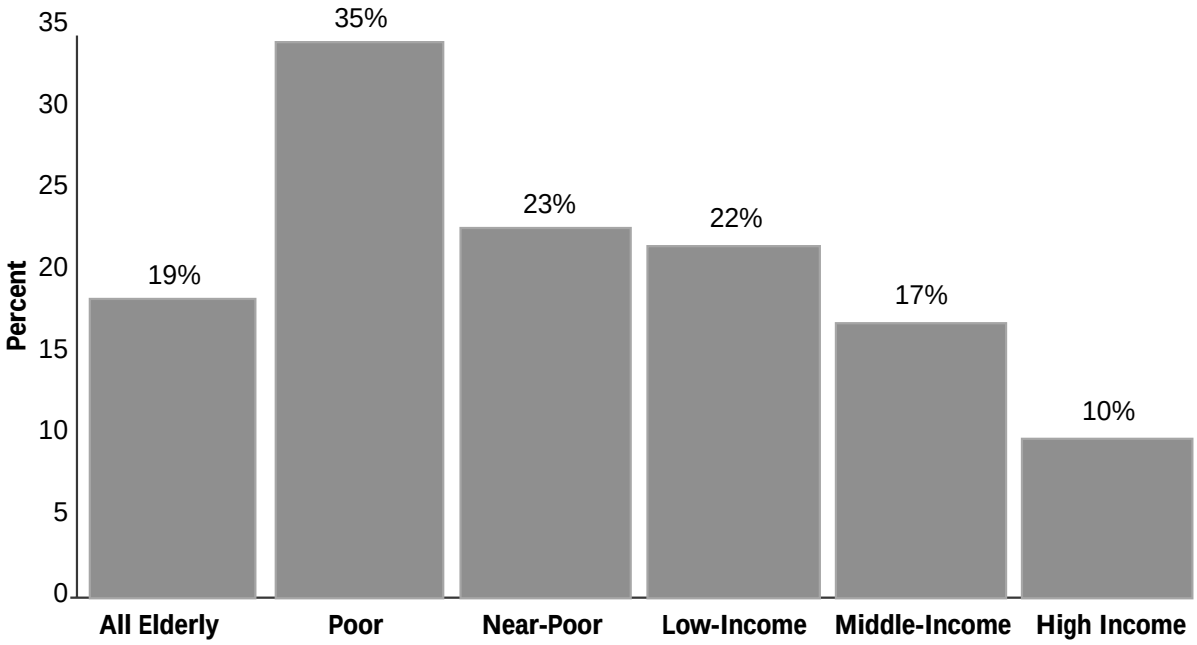
Exhibit 4



Source: The National Academy of Social Insurance, based on data from an analysis of the *1997 Current Population Survey* done by Marilyn Moon and colleagues at the Urban Institute, 1998.

Exhibit 5

Average Out-of-Pocket Health Costs for Medicare Beneficiaries* As a Percent of Household Income, by Income Status, 1997



Note: Income status definitions: poor=below poverty; near poverty=100% to 125% of poverty; low-income=126% to 200% of poverty; middle income= 201% to 400% of poverty; high-income=over 400% of poverty.

*Non-institutionalized beneficiaries age 65 and over.

Source: AARP Public Policy Group and the Lewin Group, *Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*, p. 10, Figure 5.

$31,020) devote only 10 percent of their incomes to health care.

Beneficiaries who have incomes below the poverty level but are not eligible for Medicaid (60 percent of all poor Medicare beneficiaries) spend about half of their incomes on health expenses. Appendix A table 1-5 shows out-of-pocket spending projections in 1997 dollars by income for beneficiaries with Medicaid, and those without Medicaid in FFS and HMOs (AARP PPI and the Lewin Group, 1997).

One way to think about the impact of Medicare is to estimate how out-of-pocket costs for current beneficiaries would change if Medicare did not exist. As an approximation of health expenses in the absence of Medicare, one could add current per capita Medicare spending (U.S. Congress, Green Book, November 1996) to current out-of-

pocket health expenses. For the average beneficiary in 1997, total out-of-pocket health expenses would then be about $7500 (about 25 percent of the median income of $30,660 for all household headed by persons 65 and over in that year). This represents more than three times the current average out-of-pocket costs — money that would have had to be drawn from personal budgets for housing, food, or other needs. And this rough estimates minimizes the potential economic impact of Medicare.[12] Alternatively (and probably), many individuals would have chosen to delay or ignore medical care. Severely sick people ending up in the hospital would nevertheless incur costs that rebounded to them, to their families, or to any available public welfare programs.

The current Medicare program has serious deficiencies. However, by spreading risk across 39 million beneficiaries whose health ranges from excellent to poor, and by using its size to impose favorable prices for the services it covers, Medicare provides beneficiaries with a level of financial predictability and security that most would not be able to obtain on their own (a theme we return to in the next chapter). Nevertheless, many beneficiaries still devote substantial portions of their income to health care, with those of the most limited means facing the greatest burden of choice between medical care and other essentials for healthy living.

DOES MEDICARE IMPROVE BENEFICIARIES' HEALTH STATUS?

There is a body of research that suggests that, in general, having health insurance in the United States is associated with better health outcomes (U.S. Congress, OTA, September 1993). We cannot know what the health of Medicare beneficiaries would be if there were no Medicare program, but it is possible to examine the general health status of people covered by Medicare and how their health status varies.

The basic trends in health status are good, although they may of course only be partially related to medical care. Since Medicare was created, life expectancy at age 65 has increased by two to three years (Cutler, 1998), and there have been major declines in mortality resulting from several major diseases, particularly cardiovascular disease (Cassel and Siegel, 1998). The growth in Medicare enrollment due to disability or ESRD has accelerated over time and reflects, in part, improvements in trauma care and technologies available to manage serious illness for long periods of time.[13] Longevity, more importantly, seems to be associated with better self-reported health among the beneficiary population. Data from the National Health Interview Survey show small increases from 1980 to 1990 in the proportion of elderly persons rating their health as good, very good or excellent (Cutler, 1998).

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12 It assumes that all beneficiaries would be able to purchase insurance for the current average cost of providing Medicare. Any segmentation of the risk pool could lead to lower costs for some beneficiaries and higher costs for others. Depending on regulation of the private insurance market, some beneficiaries may not be able to purchase policies at all. This estimate is an overall average that would vary substantially by beneficiaries' individual health needs, geography, and other factors. It assumes that private insurance would reimburse providers at the same level as Medicare and face administrative costs equal to Medicare's administrative costs. Evidence indicates that Medicare's costs are lower than those currently faced by private insurers (see Chapter 2).

13 Enrollment patterns for the disabled have also exhibited volatile swings over the past two decades, corresponding to changes in Social Security Disability Insurance policy (U.S. DHHS, HCFA, 1996).

There is also evidence that overall rates of functional disability have declined as a result of medical advances, healthier lifestyles, and improved medical care (Cassel and Siegel, 1998).

Medicare is a factor in the improved health status of the nation's elderly population. Recent work conducted at the National Bureau of Economic Research and Harvard University that modeled the effects of Medicare on the health outcomes and quality of life of Medicare beneficiaries concluded that "taken as a whole, the increase in Medicare spending over time has almost certainly yielded health improvements greater than its cost." (Cutler, 1998).

Health status among Medicare beneficiaries also reflects socio-economic disparities in the population. Appendix A figure 1-9 shows that self-reported health status for white non-Hispanic beneficiaries is higher on average than that for black or Hispanic beneficiaries. Individuals dually eligible for Medicaid are more likely to rate their own health as fair or poor and have more chronic conditions than other Medicare beneficiaries. This may reflect at least in part the fact that many nursing home patients, who generally have multiple health and functional status limitations, are likely to be Medicaid eligible.

The ideal old age might be defined as a long healthy period — say up to one's 90's or even early 100's — followed by a hasty, peaceful (and inexpensive) death. However, even though health status has improved since the creation of the Medicare program, aging is still clearly associated with significant increases in the rates of chronic illness and disability (Hoffman, Rice, and Sung, 1996), and Medicare and Medicaid pay for much of the medical care that results. The Medicare Current Beneficiary Survey (MCBS) annually gathers information, including self-reported measures of health status, from a representative sample of beneficiaries. Appendix A figures 1-10, 1-11, and 1-12 show three measures of health status: (1) beneficiaries' general assessment of their own health, (2) whether or not they have a "functional limitation" in performing personal care or activities necessary for independent living, and (3) whether they have any chronic health conditions. These data show that the bulk of Medicare beneficiaries see themselves as being in good health, even though 87 percent also report having at least one chronic condition. For beneficiaries age 65 and over, health status declines over time. Data from the MCBS show about 20 percent of beneficiaries age 65-74 describing themselves as in poor or fair health, compared to 29 percent in the 75-84 group, and 35 percent age 85 or more. Over 70 percent of those aged 75-84, and almost 80 percent of those 85 or more reported having two or more chronic conditions, compared to 57 percent of those aged 65-74.

Viewed in terms of clinical and supportive care needs, the Medicare program has been only partially successful. While the program has provided access to a tremendous range of surgical and medical treatments that have prolonged and substantially increased the quality of beneficiaries' lives, access to better health care has come with a substantial price tag. Cassel and Siegel, in work commissioned by the Study Panel (1998), describe two sets of costs associated with an aging population: the price of enabling people to remain healthy, and costs associated with disability-related health care needs. Medicare coverage for the first set of costs, particularly major costs associated with intensive surgical and

medical treatments, has contributed to remarkable improvements in the lives of millions of Americans. Medicare has not, however, protected beneficiaries against many of the costs of chronic and long-term care.

> *[C]onsider the case of two active eighty-year-old women, one volunteering as a docent at a local art museum, living independently; the other is the primary care-taker of three young grandchildren while her daughter works full-time as a nurse's aide. Both women have likely benefitted from a number of treatments, such as some of the following: 1) cataract surgery to improve vision; 2) hip and/or knee replacement to treat disabling osteoarthritis, 3) aggressively treated hypertension requiring intensive medical monitoring to prevent stroke or heart attack, 4) management of Type II diabetes mellitus through numerous outpatient visits and glucose monitoring, 5) coronary artery bypass surgery and/or angioplasty for symptomatic coronary artery disease, 6) breast cancer surgery to treat a malignancy, detected early by mammography; and 7) hormone replacement therapy with estrogen and progesterone, requiring regular visits to a gynecologist.*
>
> *These costly, medically-extensive interventions are among those covered by Medicare, enabling these women to maintain active lifestyles and to continue contributing to their families and their communities, Without such interventions, these patients would be considerably impaired by the natural course of these conditions, or they might not have reached the age of 80. (Cassel and Siegel, 1998).*

In an overview of advances in medical care for serious medical conditions prevalent in the Medicare population,[14] Cassel and Siegel illustrate enormous advances in pharmaceutical therapies, outpatient follow-up therapies and care management strategies, and the use of technologies that can prevent or contain sensory loss or loss of mobility. However, because Medicare provides only very limited coverage of prescription drugs (generally limited to inpatient settings), hearing aids, or glasses, and places restrictions on rehabilitative services to post-acute episodes, beneficiaries (or supplemental insurers or Medicaid) have ended up paying more, rather than less out-of-pocket for needed health care as medical care has advanced. The limitations of the Medicare benefits package have, moreover, contributed to discontinuities and lack of coordination in care for frail and chronically ill beneficiaries, and created serious obstacles to effective palliative treatment for terminally ill patients. From this perspective, the restructuring of Medicare should focus on developing efficient and cost-effective models for delivering the health and support services that the beneficiary population needs, which would include both acute care and long-term care services.

The projected growth in the number of beneficiaries over age 85 combined with the costs of the ever-growing capability of health care technology to benefit people as they age poses a fundamental challenge to policy mak-

14 The paper discusses Alzheimer's disease, Parkinson's disease, arthritis/joint replacement, osteoporosis, diabetes, stroke, malignancy, depression and psychiatric illness, and visual and hearing disorders.

ers. "Health" involves not only treating illness, but is about alleviating pain, improving mobility, improving vision or hearing, or otherwise using technology to improve quality of life. What can and should be Medicare's future role in shaping the kinds of health care available to its beneficiaries? Up until now, Medicare's reimbursement incentives have favored hospital services, for example, while largely ignoring the importance (and growing cost implications) of pharmaceutical treatment in modern medicine. If Medicare is to be effective as health insurance, its coverage policies must be periodically updated to reflect changing medical care.

MEDICARE'S OTHER ROLES

Over the course of its history, Congress has directly and indirectly mandated that Medicare take on responsibilities beyond providing health insurance for older individuals and people with disabilities, including subsidizing medical education and certain "safety-net" hospitals. The rationales for these ancillary duties fall under two broad headings. First, Medicare, as a public program, must be accountable to both enrollees and to taxpayers. Ensuring that the health care Medicare pays for is appropriate and meets beneficiaries' needs requires doing more than just paying bills. Qualified health care providers and facilities have to be available to serve beneficiaries. The primary way Medicare can affect providers and facilities is through reimbursement policies. However, because Medicare represents a large portion of all health care spending, it is also a logical means for influencing the structure of the health care system, by helping support institutions or practitioners providing important services in communities that would otherwise not be able to support needed services. Second, as the only country in the world to have a national health insurance program for its elderly and disabled but not for other members of the population, the United States has used Medicare as its version of national health insurance. Medicare has become a means of supporting more general public health and social policy goals identified by Congress and Executive Administrations. On occasion, Medicare may also have been used to achieve other social or political goals because "it is there." Arguably, it has been relatively easy for Congress to attach ancillary programs on to Medicare because the program as a whole has been so large and so popular that legislators and the public will not focus on relatively small "add-ons".

Graduate Medical Education

Medicare provides two types of subsidies to hospitals that help train medical professionals. Indirect medical education (IME) payments compensate teaching hospitals for providing more expensive services and treating sicker patients with more complicated illnesses than does the average hospital. Between 1990 and 1997, IME payments grew from $2.5 billion to $4.6 billion (Appendix A figure 1-13). Direct graduate medical education (DME) payments directly support physicians and other medical professionals in training. They grew from $1.5 billion in 1990 to $2.5 billion in 1997 (ProPAC, June 1990; MedPAC, March 1998).[15] Although spending on these subsidies has grown significantly in recent years, the $7.1 billion in total subsidies for

15 GME payments in 1997 included $2.2 billion for physician training and $300 million for the training of allied health professionals (ProPAC, June 1997).

medical education in fiscal year 1997 represented 3.4 percent of all Medicare payments.

Disproportionate Share Payments

Medicare provides disproportionate share payments (DSH) to hospitals that face higher than average costs because of their location (often in low-income, urban areas), because their patients have relatively intensive health care needs, and because they are more likely than other patients to lack insurance or other resources to pay for their care. As shown in Appendix A figure 1-13, between fiscal year 1990 and fiscal year 1997, DSH payments grew from $1.6 billion to $4.5 billion. In 1997, they represented 2.2 percent of all Medicare payments (ProPAC, June 1990; MedPAC, March 1998).

Research and Innovation

Medicare also pays for research and innovation that ultimately benefits the entire health care system. One mechanism for this investment is Medicare's research and demonstration authority. Either through Congressional mandate or HCFA's own initiative within existing law, Medicare experiments with new ways of providing or paying for services to its beneficiaries. HCFA contracts with researchers to evaluate each of these experiments with results disseminated through academic and policy literature. The results of these experiments, as well as major innovations in Medicare (e.g. the Medicare Prospective Payment System and the Medicare Fee Schedule) are available, and often adopted by other private and public health insurance systems. Furthermore, these Medicare experiments help maintain an infrastructure of experts and institutions whose efforts contribute to the study and innovation of other parts of the health care system.

Medicare also contributes indirectly to the conduct of biomedical research in the United States. Because teaching hospitals tend to conduct clinical research, Medicare payments (including the specific IME and DSH subsidies identified above) help maintain the capacity of these institutions to innovate in clinical medicine. Furthermore, although Medicare generally does not pay for experimental treatments, it will pay costs associated with the provision of "Group C" cancer drugs, experimental therapies provided free of charge by the National Cancer Institute, as well as the attendant costs of a hospitalized patient receiving experimental treatment if the admission was not solely for the experiment (U.S. Congress, OTA, February 1993).

No good quantitative estimates of Medicare's contributions to research and innovation exist. Medicare does not maintain a separate budget for all of its research and demonstration programs. In 1998 there were 18 Medicare demonstrations mandated by Congress that were either operational or in the planning stages (U.S. DHHS, HCFA, August 27, 1998). The basic research, demonstration and evaluation budget for the agency in FY 1998 was $50 million.[16] The

16 HCFA's research budget is largely directed to conducting and evaluating demonstration projects designed to test program innovations, and develop or refine payment, coverage or reimbursement mechanisms for Medicare, Medicaid and the Children's Health Insurance Program. Other research on policy-relevant health services research and medical effectiveness and outcomes topics is funded through the Agency for Health Care Policy and Research, and also by the Centers for Disease Control, and several of the Institutes of the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration.

indirect nature of Medicare's other contributions to biomedical and health services research make estimates of their magnitude even more difficult.

While direct and indirect spending for ancillary programs constitutes a small proportion of overall Medicare spending, the political importance of Medicare's other roles is integral to the debate about the program's future. We revisit the issue of whether Medicare should continue to be the vehicle for supporting other social or public goods in Chapter 2.

CHALLENGES FOR THE FUTURE

In the generation since it was established, the environment in which Medicare operates has changed in fundamental ways. The aging of the population and changes in the nature and capabilities of health technology threaten both the financing of the program, and its continuing ability to ensure beneficiaries' access to care and protect them from potentially devastating costs. In part, the problems facing Medicare are a result of the remarkable advances in medical science and in the standard of living, particularly for older people, throughout the industrialized world. At the same time, particular characteristics of the American health care (and political) environment, including aspects of Medicare's statutory provisions and program management, have contributed to problems in financing and program effectiveness. Sorting through these factors can help in evaluating options for reform.

Aging of the population and the concomitant increase in health care costs is not a uniquely American phenomenon. In fact, the United States has the youngest median age and second smallest proportion of its population over age 65 of any of the Group of Seven industrialized nations (Appendix A table 1-6). All spend more for health care for older citizens than for younger populations. There is, however, substantial variation in the ways that modern states allocate their health resources among elderly and non-elderly people (Reinhardt, 1997). Appendix A figure 1-14 displays the ratio of spending for persons 65 to 74 and those 75 and older relative to that of persons under 65, which are set at "1." Germany, Japan and the United States show a relatively high ratio of spending for people age 75 and older to those under 65 (5.7, 5.6, and 5.2 times as much, respectively) compared to the United Kingdom, Sweden and France (3.2, 3.4 and 3.7 percent, respectively).

Like their counterparts in almost all other developed countries, elderly Americans (who make up almost 90 percent of the Medicare population) have nearly universal coverage, although the benefits are not comprehensive. The limitations of Medicare's benefit package and the program's cost-sharing requirements mean that Americans must purchase supplemental insurance or pay for uncovered costs out of pocket if they do not have employer-based supplemental insurance.

The growth in health care costs is an issue of concern in all the developed nations participating in the Organisation for Economic Cooperation and Development (OECD). All have tried to develop approaches to controlling costs, ranging from the introduction of price controls, to establishing global budgets for health care services, to implementing reforms designed to apply market-based incentives to suppliers or users of health care (Schiel-Adlung, 1998). Out-of-pocket spending has been increasing among most of the

developed nations participating in the OECD. But while additional cost-sharing in the form of copayment and deductibles has been introduced in a number of countries in the past few years, it is most common for pharmaceuticals and dental services, and generally very limited for basic medical services. In addition, most OECD national health plans provide more protection from cost-sharing to individuals who have significant health care problems or who cannot afford cost-sharing requirements than do public programs in the United States (Schiel-Adlung, 1998; Oxley and MacFarlan, 1994). The United States therefore has the unfortunate distinction of spending relatively more per capita for the elderly while providing them with less comprehensive coverage with generally higher out-of-pocket costs.

Overall, the United States spends substantially more of its GDP on health care than do other industrialized nations (Appendix A figure 1-15). Differences in health care costs *per capita* are attributed to a variety of factors. Countries with higher per capita GDP tend to have higher health care costs, although this does not explain all the United States' health spending. Among other explanations, a number of researchers point to the relatively intensive use of expensive technology in the U.S., relative to other nations, as the single most important cause of higher per capita spending here (Newhouse, 1992; Reinhardt, 1997; Anderson, 1997). While some researchers have suggested that hospitals in the U.S. provide more intensive care than do similar institutions in other countries (U.S. Congress, OTA, September 1994), a recent study suggests that higher U.S. spending is due to higher prices and the larger administrative apparatus required by the large number of private and public insurers in the United States (McKinsey, 1996; U.S. Congress, OTA, September 1994)[17] Another area often suggested as contributing to higher U.S. spending is in the amount of care given at the end of life (Reinhardt, 1997).[18] Like the regional variations in health care spending across regions and even adjacent market areas within the United States, international variations in health care financing, utilization, and outcomes raise intriguing questions about health care utilization and financing, but, as of yet, there are no clear answers that are readily translatable into Medicare policy reforms.

In the United States, changes in Medicare could influence the adoption and diffusion of medical technologies and the extent to which

17 At the same time, however, Medicare's administrative costs are low relative to other U.S. insurers (U.S. DHHS, HCFA, 1996).

18 Expenditures in the last year of life represent 10 to 12 percent of the total health care budget and 27 percent of the Medicare budget. The extent to which these expenditures reflect heroic measures that exceed individual or family wishes for treatment are, however, not at all clear. Several studies have shown that interventions such the use of hospice care or "advance directives" designed to ensure that terminal patients are able to forego invasive life-extending treatment have not yielded any significant cost savings. (Emanuel, 1996) Other research has shown that even if terminally ill Medicare enrollees opted to use physicians to help them end their lives under the same circumstances as do people in the Netherlands, where assisted suicide is an accepted practice, the cost saving to Medicare would be minimal (less than one percent of program expenditures) (Emanuel and Battin, 1998). This suggests that it is not major medical interventions among people who are clearly dying, but interventions for individuals who are very sick, and eventually succumb to their illnesses, that account for the high cost of dying in America.

beneficiaries are guaranteed access to medical treatments and technologies in the future. Both prospective payment, which provides fixed reimbursement for each medical "case", and capitated payment systems, which provide for a fixed payment amount for each enrolled person in a health plan, put providers at risk for the services they use. Some analysts believe that these payment reforms may have slowed the rate of technology diffusion in some areas (Neumann and Weinstein, 1991; Sisk and Glied, 1994; Chernew at al., 1998). Further expansion of such reforms might have ripple effects across the entire health care delivery system, and in turn, the pharmaceutical and biotechnology industries. In a very real sense decisions about Medicare are decisions about the future of health care in America.

Access to state-of-the-art medical treatments and technologies in managed care settings has become a political issue, centering on consumer choice, rationing, and professional autonomy and responsibility. While managed care can provide incentives to stint on care, economic pressure could provide the impetus to identify and use more cost-effective technologies (Wagner, 1992; Sisk and Glied, 1994; Chernew, et al., 1998). Effective managed care might, for example, reduce avoidable hospitalizations for conditions such as congestive heart failure and diabetes (Cassel and Siegel, 1998). Managed care also offers important incentives to develop collaborative approaches to managing chronic illness. Such collaboration could, in theory, entail some basic reconsideration of what types of services, including social personal care and social support services, might be cost-effective for Medicare beneficiaries. The net effect of Medicare reforms on the introduction and use of technology can only be guessed; the uncertainty surrounding the future development and diffusion of medical technologies makes it virtually impossible to predict future health care costs.

While demographic change and advances in the technological capacity of medical care to benefit the elderly and disabled populations have significantly altered the environment in which Medicare operates, the organization of the delivery system itself has changed, particularly in the past ten years. In the 1990s, the private, employer-sponsored health care market responded to increases in health care costs by reducing coverage and benefits, and by developing management techniques designed to control the utilization of services and promote efficiency in care delivery. About three quarters of working Americans are now enrolled in some form of managed care (Jensen, et al., 1997). Medicare has offered managed care options for decades, but until 1997 these were limited to health maintenance organization models, and enrollment in these plans was limited.

The percentage of Medicare beneficiaries receiving health care through a "risk plan" (a health maintenance organization (HMO) or other health plan that receives a capitated payment for each beneficiary rather than fee-for-service reimbursements) is still relatively low, but has grown significantly in recent years. Risk plans accounted for 14 percent of beneficiaries at the end of 1997 (MedPAC, March 1998). For some beneficiaries, the extra benefits that risk plans provide are attractive. In addition, as more employees receive their health benefits through managed care, they may opt to keep the same health plan they used when they were employed, if it continues to be available

(and affordable) to them when they retire (see Chapter 3; Hibbard and Jewett, 1998).

The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) adopted policies that permit new types of health plans to offer Medicare services. It also changed the payment formula to health plans, a process which will increase the capitation rate in a number of counties, particularly in rural areas, where the capitation payment rates have been quite low in the past. This is expected to increase managed care organizations' interest in participating in the Medicare market in these areas (PPRC, 1997), although, as noted above, it is not yet clear how attractive the Medicare market will be to providers in many areas of the United States. The Congressional Budget Office projects that managed care and related health plans will include 17 million beneficiaries, or 38 percent of all Medicare beneficiaries, by 2008.

In theory, managed care offers opportunities for increasing the coordination and effectiveness of health care services for the Medicare population. As noted above, better integration of preventive, acute care, and home and community-based rehabilitative and support services could lead to better, and more cost-effective care for chronically ill beneficiaries (Cassel and Siegel, 1998). The expanding array of plan options that will be made available to Medicare enrollees is intended to give health care providers in the private sector incentives to develop better ways to manage care, so that they can compete for Medicare enrollees on the basis of quality of care and cost. The administrative structure of the "traditional" fee-for-service component of Medicare, however, has remained largely the same as it was when it was put in place. Medicare is run by HCFA, under close scrutiny by the Congress. Whether HCFA's organization, resources and regulatory authorities provide the infrastructure the agency needs to be responsive and effective in managing Medicare in the next century is an integral part of the debate about Medicare's future, as we discuss in Chapters 2 and 4.

The evolution of a market-based health care system in which health plans compete for beneficiary enrollment raises an array of issues related to oversight and consumer protection that are substantively different from those in a fee-for-service, indemnity insurance system (including traditional Medicare). In fee-for-service systems, providers are reimbursed for each service they provide; more services to patient result in higher reimbursement to providers. Beneficiaries' costs increase with greater use of services as well, but these costs are, for most beneficiaries, buffered by supplemental insurance. Therefore the incentives have generally favored more use, and possibly overuse of "discretionary" services, that is, non-urgent physician visits and use of tests and medical procedures (NASI, January 1998). Under capitation arrangements, used in payment for managed care organizations, a fixed payment for each beneficiary is agreed upon in advance. This can provide economic incentives for these health plans to enroll as many healthy (potentially low-cost) beneficiaries as possible, and avoid enrolling high-cost beneficiaries, or to stint on care for high-cost enrollees. It is also assumed, as a tenet of market-based competition among health care plans, that consumers will make good choices about which plans to select and about the use and quality of health care services. Whether the information that beneficiaries need will be available, and whether public

agencies, benefits administrators, plans, and providers can collectively develop an accountable infrastructure to ensure program integrity, efficiency, effectiveness and quality in the delivery of services, also need to be part of the discussion about Medicare reform options.

CONCLUSIONS

Medicare was created as a response to a serious problem. The private market did not and could not work for a large proportion of the nation's elderly and disabled population. Medicare has improved the health status of the elderly in America. The program has been a central factor in reducing anxiety about medical bills, and in providing access to health care that extends life and increases the quality of life for millions of people.

Medicare's ability to fulfill its goals is now threatened from two opposite directions by the same basic problem: health care costs. From a program perspective, projected health care expenditures exceed the revenues available to fund the Hospital Insurance program as it is currently structured much beyond the next decade; expenditures for Part B account for a growing drain on the total domestic budget. Although the aging of the population has contributed to the problems that Medicare is facing, the major factor driving the relentless increase in Medicare outlays is the increasing use of services for individual beneficiaries. As it turns out, neither demography nor inflation is the main cause of Medicare's fiscal problems; it is the intensity of services per beneficiary. Failing to address this fundamental issue could lead to policies that, over time, might deny much of the Medicare population the benefits of future medical advances, whether by rationing by price, by beneficiaries' ability to pay, or by excluding coverage for some services.

From a beneficiary perspective, the inadequacies of the benefits and increases in cost-sharing are causing Medicare to fall behind in its goal of providing financial security to beneficiaries and their families. The current package no longer reflects the way that medicine is practiced; the access to care and protection from financial ruin promised by Medicare is being eroded by the costs of prescription drugs and potentially catastrophic levels of cost-sharing. While expanding benefits would likely increase program costs, broader benefits might also facilitate better management of chronic and long-term illness and disability, and reduce some of the inefficiencies associated with the current patchwork of supplemental insurance. It is the view of the Panel that options for securing the Medicare program for the future must address the fundamental issues of what health care services Medicare will pay for, what mechanisms will determine how coverage and benefits will be adjusted to meet future circumstances, what portion of those costs can and should be borne by individual beneficiaries, and how the costs of care for those beneficiaries who cannot afford their share of payments will be allocated across other public programs, particularly Medicaid.

As the Study Panel worked through how to describe the current Medicare program and the implications of making significant changes, it came back, again and again, to how organizationally and politically difficult it is to separate Medicare from its larger social contexts. Over and above the political history of the program and subsequent demographic changes and changes in medical practice and its costs, two rather different

contexts should be emphasized, one private, one public. First, Medicare was designed to be an intrinsic part of, and to support, a private market-based health care system of insurers and providers. Medicare must thus be evaluated as one player in an interdependent, public-private financing and delivery system. In this first role, Medicare has, like the private insurance sector, had some limited successes using economic incentives to control costs. But, unlike the private sector, the program has not been able to take an active role in restructuring the way that most of health services it pays for are actually managed. Second, though limited in its population coverage, Medicare is, nevertheless, a form of national health insurance and, as such, it carries public burdens over and above the provision of health insurance to its beneficiaries. In this second role, Medicare subsidizes social goods and exerts leverage in broader areas of health and social policy that would most likely be part of national health insurance and policy in other nations. Separating such activities from Medicare would require Congress to develop national health policy for resources, research, and development much more overtly than at present.

Decisions about Medicare's future, including its ability to deal with health care utilization and costs, will not (and cannot) be made on purely economic or medical criteria. Medicare has become part of America's infrastructure. It reflects deeply-held social and political values, and any reforms must reflect these if the reforms are to be successful. In the following chapters, we examine these values and beliefs as they relate to Medicare's role as social insurance, and as they are expressed by the American public.

Chapter 2:
Medicare as Social Insurance

American policy makers have the difficult task of evaluating a variety of Medicare reform proposals, not only in terms of how these policies would affect the financial stability of the program, but also how they will meet public expectations, how they will fulfill the program's larger goals, and how they might change the American society that Medicare has helped shape. The basic question is a simple one:

"How important is it to retain Medicare as a social insurance program?"

We begin this chapter by reviewing the risks that Medicare is designed to cover and the roles Medicare assumes as a social insurance program, the form it has now held for a third of a century. We then return to the ancillary roles that Medicare has assumed, and consider how these mesh with the program's social insurance functions in the contemporary political environment.

MEDICARE AND THE QUESTION OF RISK

Medicare was designed as a social insurance program rather than as a social welfare program. This means that 1) it is paid for, at least in part, through mandatory contributions, determined by a formula established in law, from individuals and / or employers; 2) it provides benefits that come from a fund earmarked for the this purpose; and 3) it pays out these benefits under the same set of rules for all qualified individuals, who regard the benefits that they will receive as "insurance " to which they contributed over time (see below). As a social insurance program, Medicare provides a set of benefits defined in law to all eligible individuals, as an earned right, irrespective of health condition and without the requirement of a means test.

Health insurance, whether in the public or private sector, covers individuals against the costs of unpredictable illness and disability by sharing individual financial risks across a large population. The health risks among individuals in the Medicare population vary enormously from person to person, far more so than among the working population. Most people, even those who are elderly and disabled, do not incur a lot of health care costs in a given year. But some of those who do need health care incur very high costs. In 1992, for example, about 23 percent of beneficiaries accounted for over 78 percent of all personal health care expenditures for Medicare beneficiaries. The inpatient hospital costs alone for the "highest-cost" beneficiaries (the top five percent in total charges, excluding those in long-term care facilities) averaged $34,478 (Laschober and Olin, 1996).

The risks against which Medicare insures its beneficiaries apply to all participants. That is, virtually all people who reach eligibility age (65) or can no longer work due to disability face the risk of health care costs that could exceed their ability to pay, consume all of their savings (which would otherwise pass to the next generation) or threaten their ability to live adequately. Unlike individuals in other insurance pools who may change health insurance carriers when they change jobs, or move, or change family circumstances,

Medicare beneficiaries rarely leave the program before they die. Many incur health care costs, sometimes very high costs, before they die. No individual can predict from an early age what the "wheel of misfortune" will bring: perhaps cancer, stroke, diabetes, Alzheimers disease, neurological disease, hip fracture or spinal cord injury. The way these risks play out for individuals, families, and communities may be shaped by the epidemiology of disease and perhaps sometimes by genetics, but may also be linked to socioeconomic factors, risk behaviors, and just plain luck. The point is that none of us knows the health risks we will face, what care our health care problems will involve, or what they will cost. Medicare is designed to address some, but not all, of the risks for its beneficiaries (Moss, 1998).

Five types of risks shape the health insurance environment for Medicare as a program whose focus is on elderly and disabled individuals. These risks vary somewhat from the risks addressed by social insurance for health care in other countries; in a national health insurance program which includes all ages, these risks would be distributed across a larger, younger, healthier population.

First, the great majority of people cannot predict, with great accuracy, how long they are going to live after retirement *(longevity risk)*. For some people, there is real uncertainty about when they are going to retire, or even whether they will live to retirement age. In the absence of guaranteed access to a health insurance program that people know will be available and affordable for people past the age of retirement, individuals would have to predict how much they needed to save prior to retirement in order to have enough money to buy insurance, or pay out-of-pocket for future health care expenses for one, or two, or even three or more decades. This is the kind of calculation Americans are expected to do to plan for retirement income; people are supposed to view Social Security as a floor of protection, and plan early in their work lives so that they will be able to supplement their retirement income with private savings and pensions.[1] But predicting one's own longevity risk is actually impossible to do rationally. Should one expect, for example, to live to be one hundred, and save accordingly (which could mean depriving oneself, or family members, for decades in order to save enough for the future), or assume that she will live only to 66, and not save at all? Medicare insures against longevity risk by spreading this risk among all those paying into the program, and promising coverage to beneficiaries no matter how long they live (Moss, 1998).

Second, *health risk*, i.e. the uncertainty of encountering a costly illness (and not being able to pay for it) is greater, in economic terms, in the Medicare population than in many other insured groups. While the distribution of high-cost illnesses is concentrated in a small proportion of individuals, as it is in the general population, the absolute costs are higher among elderly and disabled populations. Per capita health care spending for people aged 65-74 is about three times greater than the population under 65; for beneficiaries 75 or older, it is more than five

1 In identifying the basic information that the public should have about retirement income, the Social Security Administration included as a measure of public understanding the percentage of adults who know that "their personal retirement program should include Social Security *plus* other income from savings or pension programs" (Toler, 1998).

times as much (see Chapter 1).[2] More important, high-cost users of Medicare are more likely to have chronic conditions and functional disabilities, and for these beneficiaries, high costs tend to continue over a longer period of time than among younger "high-cost" patients (Laschober and Olin, 1996; Gruenberg, Tompkins, and Porell, 1989). The purpose of health insurance is to pool these risks, so that the costs can be spread among the population. In commercial markets, underwriting to protect against this high degree of risk, individual by individual or group by group, leads to setting premiums at levels that many people cannot afford.[3] Medicare pools the risk among the entire covered population, but also ensures that everyone who has contributed is guaranteed coverage, with fixed contributions for all participants, regardless of health risk (Moss, 1998).

A third set of risks are artificially constructed, but real in their consequences: Medicare, like most employment-based health insurance in the United States and other industrialized nations, does not cover all of the health risks of beneficiaries. The actual design of benefits may be flawed, or become inadequate over time; this could be termed *coverage risk*. In 1965, when Medicare was enacted, it was designed to pay mainly for high-cost hospital care, because that appeared to be the biggest problem in health care financing at that time. Since then, the financial burdens of long-term and chronic care have also become serious threats to health care and financial security. Although expenditures for home health care in particular have been increasing rapidly, Medicare still provides only limited coverage of sub-acute care services (home health, nursing home and rehabilitation services), and, technically, no long-term care services. For many, including many otherwise "middle-class" Americans, Medicaid has become the ultimate payer for long-term care services. Between 1990 and 1995, Medicaid expenditures for long-term care services for the elderly grew at an average annual rate of 10.9 percent per year, to over $30 billion (Liska, et al., 1997). Medicaid payments accounted for almost 38 percent of all expenditures for nursing home care for the elderly in 1995 (U.S. Congress, CBO, May 1998). Whether Medicaid should take on this role is moot. For large numbers of Americans in nursing homes, there is no other choice.[4]

Even for health care that is covered by Medicare, beneficiaries face significant finan-

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2 Estimates developed from National Medical Expenditure survey show per capita spending for the civilian, non-institutionalized population under 65 at $1,956.73 in 1996, and $7,564.02 for people aged 65 and older (U.S. DHHS, AHCPR, December 1997).

3 Risk-adjustment methodologies provide a means to adjust capitation payments to health care providers without relating beneficiaries' own portion of premiums to their health status or anticipated need for health services. These methods are, however, only beginning to provide even modestly successful means of predicting use of Medicare services (NASI, April 1998)

4 The market for long-term care insurance has been growing in the United States, but its costs may make it inaccessible to many older Americans. Younger people, in addition to having other priorities for their often limited discretionary income, may feel skeptical about whether a particular company or policy will be there for them when they need it decades into the future. At the end of 1996, about 5 million long term insurance policies had been sold in the United States, about four-fifths of these to people over the age of 65. The average annual premium for these policies was $1,505 in 1994 (HIAA, 1998). According to surveys conducted by one major long-term care vendor, those buying long-term care insurance were significantly wealthier than their counterparts in

cial risk. The 20 percent copayment for physician services, along with hospital deductibles and limits on the number of covered days for inpatient stays, can leave seriously ill people with large medical bills. As we discussed in Chapter 1, most beneficiaries have some form of additional coverage. This may be provided, in full or part, by employers or former employers, purchased in the private market, obtained in Medicare managed care plans, or provided or subsidized by government. If beneficiaries do not have secondary insurance, or that insurance does not adequately cover these costs either, the costs are borne by beneficiaries, their families, or other public programs, such as Medicaid.

The fourth type of risk facing beneficiaries revolves around the fact that the actual costs of health care *(technological risk)* at any given point in the future cannot be predicted with any certainty (Moss, 1998). Even if we as individuals knew, at a given point in time, what types of health care we were likely to need in the future, neither the technology that will be available to meet our future needs (including technologies that may enhance health care but that have not yet been discovered) nor the costs of that technology are predictable. Medicare currently assumes the health care and technological risks by providing guaranteed coverage, for all beneficiaries, of the health care benefits that are defined in law and regulations, as long as the services are deemed medically necessary and appropriate. While Medicare does not cover all medical services or procedures, it has, historically, covered an increasingly sophisticated array of medical treatments and procedures (Cassel and Siegel, 1998).[5]

Fifth, individuals also face *economic risk* that can undermine their ability to save for future health care needs. Suppose we had a pretty good idea of how long we were going to live after retirement, and how much our health insurance is likely to cost. We still would not know how much to set aside to pay for future insurance coverage, because we cannot predict how financial markets will perform over our lifetimes. Medicare currently assumes market risk by guaranteeing to pay the large share of health care premium costs regardless of financial market conditions. Similarly, Medicare guarantees against defaults in the insurance system. In private insurance systems, an insurer that offered a defined benefit for post-retirement health care could fail; a government system can protect against default risk because it can draw on its ultimate authority to tax and to borrow and to print money to cover program costs (Moss, 1998).

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the population: 38 percent had incomes over $35,000 per year (compared to 17 percent in the general population aged 55 or older), and 41 percent had total liquid assets of over $100,000 (compared to 7 percent in the general population aged 55 or older). Two comparable surveys conducted by the same vendor indicate that the proportion of those buying long-term care insurance with incomes of less than $20,000 actually fell from 1990 to 1994 (from 29 to 21 percent) (HIAA, 1998)

5 Medicare does not (with certain special exceptions) cover new technologies until it is determined that they are no longer experimental. Setting out formal criteria for determining coverage for new technologies has been a very difficult issue for the program (Buto, 1994). The introduction of new technologies, therapeutic regimens, and surgical procedures in the Medicare population suggests, however, that as the program is currently configured, it has not posed major barriers to the introduction of new technologies, including technologies that are quite costly. Additional discussion about the implications of changes in the organization of health services for the diffusion of health care technologies is also included in Chapter 1.

MEDICARE AND SOCIAL INSURANCE

Discussions about the future of Medicare need to begin with the fact that the health care risks facing the Medicare-eligible population cannot be addressed in the private health care market at a cost that everyone can pay. In social insurance programs, the government takes on a risk management function, by establishing a system for pooling risks across the population. But because the actuarial costs of health insurance will still be too high for some people to afford, government also uses its authority to redistribute resources to make sure that everyone is covered. In the United States, as in other industrialized nations, a government-run social insurance program was created to manage this risk and guarantee universal coverage (in this case with that coverage taking effect when people reach retirement age or become disabled). Social insurance has been part of capitalist economies for a long time now, for good reasons. It provides protection for individuals without interfering with the operation of the private economy. The individual is protected against risk, and the employer's only obligation is to pay a prescribed percentage of payroll, avoiding liabilities for benefits; the state is relieved of potentially enormous welfare costs for elderly citizens. The logic of social insurance is pragmatic and adaptable to a wide range of social and political circumstances. It is "insurance" because it works like other forms of insurance by pooling risk. It is "social" because of its role in protecting large numbers of people who would not otherwise be able to purchase insurance in the marketplace.

The "Insurance" Component

The social insurance programs that have been put in place throughout the world differ in detail, and in some fairly important programmatic ways, but there are basic characteristics that differentiate social insurance from other approaches to providing for social need. The Panel draws on a definition of social insurance developed by the American Risk and Insurance Association and a review by Thompson (1994), to identify seven characteristics that distinguish social insurance as it applies to Medicare:

1. Compulsory Participation: Social insurance programs are usually mandatory for most or all of the population. Medicare Part A is a mandatory national program; participation in Part B is voluntary, but tied to participation in Part A.

2. Government Sponsorship: Governments create and supervise social insurance programs. The programs may, however, be administered, under the scrutiny of the government, by private sector institutions, by a combination of public agencies and private contractors (as Medicare is), or directly by a public sector agency (the Social Security model).

3. Contributory Finance: Most of the resources needed to run the program are raised through explicit contributions (taxes) on payroll (collected from employees, employers or both), or from other taxes or earmarked revenues. Medicare Part A is funded mainly by a flat-rate contribution by employers and employees; part B through general revenue and beneficiary premiums.

4. Eligibility Derived from Prior Contributions: Eligibility for benefits under social insurance programs depends on an individual either contributing currently or having previously contributed for a minimum period. Medicare eligibility combines both prior contributions and premium payments by current beneficiaries, with special provisions for "buy-in" for individuals who did not pay into the system as employees. In many social insurance systems, an individual's contributions also make family members eligible, as is the case for spouses of covered persons in Medicare.

5. Benefits Prescribed In Law: Uniform sets of entitling events and schedules of benefits are developed, announced, and applied to all participants. The provisions of the law and regulations, not employers or Medicare administrators, determine who should get benefits or how much they should get.

6. Benefits Not Directly Related to Contributions: Social insurance generally provides a prescribed benefit, and often redistributes resources from higher-income persons (who contribute more to the insurance program through taxes) to lower-income persons. Program payments for health care premiums generally redistribute resources to lower from higher income groups; from a social utility standpoint, social insurance allows lower-income people to obtain the same coverage as higher-income people.[6]

7. Separate Accounting and Explicit Long-Range Financing Plan: Social insurance contributions are usually earmarked to pay the social insurance benefits. Governments typically keep separate accounts that permit comparisons of program receipts and program benefits, though they may also present financial information that integrates the social insurance programs with other government operations. In the case of Medicare, the Part A Hospital Insurance fund receives most of its revenues from payroll taxes (employers and employees), but the Part B Supplementary Medical Insurance Trust Fund draws mainly on general federal tax revenues (see Chapter 1). Governments typically develop an explicit plan showing that projected revenues are sufficient to finance projected expenditures for several years into the future (or, if revenues are not sufficient, explaining how the government proposes to balance projected receipts and scheduled benefits).

6 Because Medicare reimburses many providers on an indemnity basis however, program outlays are a function of the actual utilization of health services. Some analyses suggest that because higher-income people live longer and also use more health care resources per capita than lower-income people, there is actually a net redistribution of benefits from lower income to higher income people The value of Medicare insurance may, however, be far greater for low income people, who, without Medicare, would have very limited if any access to health insurance at all (McClellan and Skinner, 1997).

The "Social" Component

Social insurance is more than a publicly-run program to provide insurance to people who could otherwise not be sure of having it. It is a vital part of the social policy of modern market economies. The American financial market has never offered a savings vehicle that can guarantee individuals at the beginning of working life that when they reach retirement age, or have to retire due to disability, they will have access to needed and potentially available health care and that this access will not result in financial destitution. As in other industrialized nations, social insurance in the United States is rooted in the understanding that competitive market economies do not provide adequately for all groups that political judgment suggests should be served — including individuals who have retired with life savings that would be adequate if health risks were not an issue. The market cannot guarantee basic health care or subsistence level financial security to all. If fact, markets are not meant to serve such a function; markets need to be free of social equity constraints to work with maximum efficiency.

> *Would the private sector today offer a conscientious 20 year old who wishes to engage in prudent life-cycle planning a set of financial contracts that would guarantee that there will be sufficient money at age 65 to purchase an adequate health insurance plan for the rest of her life?*
>
> — Study Panel on Medicare's Larger Role meeting notes

To promote the social stability needed to support a market-based economy, governments guarantee that if people contribute to social insurance programs when they are working, they will have some protection against total destitution when they can no longer work (Dionne, 1998).

As we discuss in detail in Chapter 3, the "social contract" embodied in Medicare is real and meaningful to many Americans. It reflects not only a concept of personal and family security, but also one of social commitment. The predominant mode of financing social insurance programs, taxes on wages while working, is designed to reinforce the notion of social obligation and interdependence among generations and across social classes. The majority of Americans want Medicare to be there for them and for their children and grandchildren, and most are willing to pay more to preserve the program. Medicare is a public program that people like.

Typically, social insurance programs are designed to spread risk widely across most or all population groups. In the United States, unlike other nations with government-sponsored health insurance for the whole population, the actual benefits are only provided to participating individuals after they reach the age of retirement or they become unable to work due to disability. This makes it more difficult to sort out Americans' social obligations or commitment to community from issues of intergenerational equity. Because Medicare is largely age-related, all sorts of issues about how resources should be allocated across generations emerge. Is it fair, for example, to burden one age cohort with higher taxes to help pay for benefits for older cohorts, particularly if these older cohorts happen to include a larger-than-average number of people? What goes into the calculation of "what is fair?" If we create an intergenerational balance sheet, should we include all of

the investments that have been made by those who are now beneficiaries on behalf of the younger generations, in housing, education, and health care, etc.? Can health care for the elderly and disabled be disentangled from other forms of health care and other social programs in a way that makes sense in terms of financing or social policy?

Two historical features of health insurance have stimulated the intergenerational debate in the United States. First, policy choices have made private insurance the foundation for providing health care for most (about 70 percent) of Americans who have health insurance (U.S. Bureau of the Census, 1998). For better or worse, private insurance is the touchstone against which other forms of insurance tend to be appraised. The problem deriving from this choice is that while the standards for coverage and benefits are set by the private market, most older people and people with disabilities cannot afford the market price of insurance they need. Even the supplemental insurance market that developed to fill gaps in Medicare coverage is beyond the means of a growing number of beneficiaries.

Second, it has been possible, politically, to make a successful case in the United States for a national system of health insurance that is a mix of employer-sponsored and private financing, with government financing for retirees and people qualifying for disability pensions. Until recently this public-private mix has worked well enough to counter claims for universal national health insurance, on the one hand, and to avoid intergenerational conflicts, on the other. Financing Medicare with payroll contributions linked generations in a common commitment that was shared by working people and their retired parents and grandparents. As a society, we have not yet fully appreciated the impact of recent changes. Now, even though employer-sponsored insurance remains the predominant form of health insurance among the working population, private insurance coverage for workers is becoming less generous and generally less available, or less attractive (in terms of coverage or premium costs) to workers in some sectors of the economy (Ginsburg, Gabel, and Hunt, 1998). The number of uninsured (throughout the entire year) in America had grown to 43.4 million people by the end of 1997; many of the uninsured are in the workforce[7] (U.S. Bureau of the Census, 1998). At the same time the aging of the population and intensity of the medical care that is now technically possible are placing unprecedented pressure on the entire health care system, and possibly the notion of mutual commitment engendered by social insurance as well.

One current critique lays out a single but strong intergenerational formula for the future. It begins with the premise that the rising costs of health care and the growth of the population entitled to Medicare will mean that, as long as the program is financed in the way that it is now, the younger, working population will have to bear an increas-

7 Of 144.6 million workers, 53.0 percent had employment-based insurance policies in their own names in 1997. The percentage of people without health insurance ranged from 8.1 percent for people with household incomes of $75,000 or more, to 25.4 percent for people in households with incomes of less than $25,000. Among full-time workers who were poor (below the poverty level), 49.2 percent were uninsured for all of 1997. People employed in small firms were less likely than those in larger firms to have health insurance. (U.S. Bureau of the Census, 1998)

ingly high burden to pay for the health care of the elderly as well as for their own increasing costs for coverage in the private health care market. In this view, rather than reinforcing the concept of mutual obligation, the financing mechanism itself foments intergenerational hostility. It is not fair, in this view, to expect younger generations to pay into a program that will finance the health insurance of a large cohort of retired people, irrespective of income, if it will not be able to meet their own needs when they retire. In such critiques and the debates they engender, we see efforts to create a touchstone of fairness, if not across the whole population, then at least in terms of specified generations.

Such perspectives seem to assume that while Medicare might be changed radically through legislative fiat, the private insurance sector would remain relatively unchanged and available to provide insurance coverage to most members of the population. This reflects the historical presumption that private insurance is the standard for America, and will continue to be so. If it is assumed that the private market will be able to offer insurance products that will meet future generations' needs, then it might make sense to focus policy reforms on maintaining each generation's access to that insurance market. In one set of proposals the solution to Medicare's financing problem, defined as an undue burden on the young to pay for the old, would be to have each age cohort pay for its own present and future health insurance needs. Cohorts (however defined) would pool their own collective risk, but each cohort would be on its own, presumably with government programs for the poor (such as Medicaid) as a "backstop" for those who fail to contribute enough on their own. Because each cohort would know that they were pooling only their own resources, in this view, there might be greater awareness of the need to use health care resources more carefully, leading to slower increases in overall health care costs.

A second intergenerational perspective assumes that the broader social benefits of social insurance ought to be preserved, and that this could be done by reconsidering, and perhaps renegotiating the *terms* of the social contract so that the contributions and benefits are allocated across age cohorts as equitably as possible. In this view, the concepts of "the young" versus "the old" or "wage-earners" versus "beneficiaries" are overly simple. Actual people move from being wage earners to being retirees. The intergenerational equity question, from this perspective, is not whether it is "fair" for the young to pay for the old, but whether it is possible to structure social insurance in such a way that it is capable of functioning over the life span of all participants, so that it can meet the needs of each cohort when it becomes eligible. The basic principle of spreading risk across generations is critical from this perspective: each age cohort pays enough to insure that there will be a program that can provide them, but also future generations, with security over time (Daniels, 1988). Because the private market can't be relied upon to provide the protection that many people need, the burden is on the government, rather than on the private market, to manage intergenerational pooling of resources effectively.

Estimating what contributions from those in the workforce are appropriate, or how other revenues should be used to finance a social insurance program is technically and politically challenging. To maintain equity, it may be

necessary to redistribute the burden among generations — older generations may be able to, and need to, contribute a larger share at some points in time. However, the Panel believes it is unlikely that any single policy change will provide a permanent, equitable solution; "equity" itself is a work in progress. The political challenge is to find efficient and politically acceptable ways to make decisions about how to keep the system stable over time.

SUPPORTING BROADER HEALTH INVESTMENTS

The assumptions supporting Medicare as social insurance for the elderly and disabled do not necessarily extend to covering related public functions or social goods that Medicare has acquired. As a very large, publicly financed social insurance program, Medicare has come to fill roles that no other private or public organization in the United States has filled (see Chapter 1). As a result, the debate about Medicare raises questions about which, if any, of these additional roles should be maintained as part of the program. In terms of direct costs to Medicare, the most important programs created by the Congress that use Medicare as a means to support the wider health care system are subsidies to rural hospitals and disproportionate share hospitals (that treat large numbers of people who are un- or underinsured), and support for graduate medical education.

In addition, Medicare has become the most important supplier of data for research on health care utilization, costs and, increasingly, on the quality and outcomes of health care in the United States. Despite severe constraints on its discretionary research budget,[8] HCFA has conducted, supported, and worked collaboratively with other agencies to generate path-breaking research in the areas of health care financing, organization, and service delivery, technology assessment, consumer education regarding choices about managed care plans, providers and services. It is important to note that the international leadership of the United States in health services and outcomes and effectiveness research grew, in large part, out of work done with Medicare data.

As pressure to contain spending in Medicare has mounted, the logic and efficiency of these supplemental roles has increasingly come under scrutiny. Questions center on 1) whether these supplemental activities are needed at all; 2) whether, if there is agreement that these are legitimate and important things for government to do, they should be done under the auspices (and budget) of the Medicare program rather than spread among all insurers or through some other vehicle; and 3) if the answer is again yes, how much of the responsibility should be borne by Medicare, and what proportion by other players in the health care system?

8 As noted in Chapter 1, HCFA's budget for research, demonstrations and evaluations (for Medicare, Medicaid and Children's Health Insurance Programs) totaled $50 million in FY 1998. This constituted less than a quarter of one percent of Medicare program outlays. The Department of Health and Human Services also taps agencies in the Public Health Service to create a fund to support policy-relevant research, much of which has been used to support the work of the Agency for Health Care Policy and Research. Funding for this research has fallen from earlier levels, to about $146 million in FY 1998, about 40 percent from the evaluation fund. Congressional appropriations (not counting funds tapped from other agencies) for health services research at HCFA and AHCPR combined totaled about $140 million in FY 1998, compared to Medicare outlays of over $200 billion.

In a paper commissioned by the Study Panel, Michael Gusmano and Mark Schlesinger examined the arguments for and against having "ancillary" activities designed to benefit the health care system that are supported by the Medicare program. The view that the government should take on responsibilities such as supporting hospitals or medical education is often couched in economic terminology. "Public goods" are goods or services which are available to or benefit everyone. National defense, or clean air and potable water, or basic scientific research are examples. Providing these goods is a legitimate function for government via tax revenues, because private markets are unlikely to generate goods and services that are available to the entire population (and not just to those who pay for these goods or services). Other government programs provide benefits that are enjoyed by local communities or markets. Examples are local public hospitals or trauma centers. A third type of good or service that might be subsidized by government is "mixed goods" which are purchased primarily for personal use, but which can provide benefits for a wider community, such as products that encourage better health or improve safety.

In addition to reviewing the literature examining Medicare's supplementary roles from a wide variety of disciplinary and political perspectives, Gusmano and Schlesinger conducted interviews with a diverse set of congressional staffers, administration policy staff, and interest group representatives, and conducted structured focus group discussions at senior centers with Medicare beneficiaries in the New Haven, Connecticut metropolitan area. Among both the policy experts and the beneficiaries they spoke with, they found fairly high levels of support for Medicare involvement in supplemental activities, including support for graduate medical education, rural health care, and research activities. However the policy experts were, not surprisingly, often divided sharply on ideological grounds. At the "liberal" end of the ideological spectrum, the view was that these other roles for Medicare made sense because Medicare's sheer size lends itself to providing such services economically, and also because the program provides a vehicle for leveraging the health care system in behalf of beneficiaries. For example, Medicare policies that are designed to increase beneficiaries' access to care in rural areas also help support health care facilities that serve the communities as a whole. Among those identifying themselves as more "conservative", the authors found some support for government involvement in these activities (particularly for local social goods such as rural trauma centers), but there were strong objections to using Medicare trust fund money for these purposes, on the grounds that the trust funds are solely and properly intended to support health insurance for the beneficiary population.[9]

The Gusmano and Schlesinger analysis brings into sharp focus the basic issue that underlies any discussion of Medicare: what is the core mission of the program?

> …if Medicare is seen primarily as a means of providing access to health

9 Although graduate medical education payments are made through the payments to hospitals, and therefore come from the HI Trust Fund, a growing proportion of Medicare revenues come from general revenues in Part B. If payments for graduate medical education or disproportionate share facilities came from Part B, it is possible that views about the appropriateness of these subsidies could change.

insurance, many of its supplementary activities would likely be judged beyond the appropriate scope of the program. On the other hand, if Medicare is seen as responsible for the health *care*, or even more broadly, the health *status* of America's elders, the scope of appropriate supplementary functions is likely to expand as well. Similarly, if activities are deemed appropriate to Medicare only if they have direct consequences for its beneficiaries, then a number of its current supplementary activities seem quite out of place. But if Medicare is seen as part of a broader intergenerational social contract, then some otherwise inexplicable additions to the program make sense in that they address the balance of the public benefits going to different age groups. (Gusmano and Schlesinger, 1998)

SHAPING HEALTH CARE AND SOCIAL POLICY

As a national social insurance program, Medicare's larger social role also speaks to American social policy as a whole. Although the political history of Medicare is one of typically American pragmatism and compromise (Stevens, 1996; Brown, 1996; Blumenthal, Schlesinger, Drumheller, 1988; Ball, 1998), the program stands as one of the main pillars of American social legislation — and perhaps also of economic legislation. Together with Social Security and Medicaid, Medicare is "the basic insurance policy Americans have for social stability, a modicum of social justice, and a society in which risks are taken freely and energetically because there is some protection against catastrophe and social breakdown" (Dionne, 1998).

As discussed in Chapter 1, Medicare works in conjunction with other programs, including Medicaid and Department of Veterans Affairs health programs. For example, supplemental payments funded through Medicaid cover Medicare premiums and cost-sharing that are entirely beyond the means of low income people. The Panel emphasizes that changes in Medicare that would increase beneficiary cost-sharing might well increase the financial burden on other public programs, or the costs that would have to be assumed by families, or both.

> *…Mrs. Brown spends up to $400 for medications, more than 30% of her income. Prilosec calms her stomach but sets her back $102.59 for a 30-day supply. Then there are Norvasc for her blood pressure ($43), two inhalers to help her breath easier ($88 total), two pain medications ($70), nitroglycerin patches for angina ($27.89) and Theophylline to clear her lungs (a bargain at $16.37). Recently, her doctor prescribed Miacalcin, a nasal spray that helps strengthen her bones but depletes her purse by $55.43 a month.*
>
> *"I need help, I need help real badly," Mrs Brown says in a raspy voice. She worked for years as a short-order cook and as a caretaker for Alzheimers patients, but she gets no pension, living on $780 a month in Social Security and $500 a month in rent from a boarder. She ran up more than $12,000 in credit-card charges between 1994 and 1996 to buy the medications she couldn't afford. Her daughter, Rebecca, who lives with her, took a second mortgage on their home to pay off her mother's high-interest*

debt, but Mrs. Brown has had to charge another $2,500 in drugs. She recently resorted to applying for food stamps, but was given only $10 a month in benefits.

— Lagnado, WSJ, 1998

Changes in Medicare that extend the current array of benefits could reduce the need for supplementary programs, or for private supplementary insurance, and, perhaps more important, restructure benefits provided in health plans to better meet beneficiaries' needs.

Medicare's impact on American society has extended even beyond its effects on the financing and utilization of health care in America. The sheer size of the program has made it a lever for social change. Desegregation of hospitals in the 1960s was a case in point, as described by Robert Ball:

…just months before Medicare was to start paying for hospital services and while hundreds of hospitals were not yet certified, the program had a thousand inspectors in the field, visiting hospitals to make sure that blacks and whites were being assigned to semiprivate rooms without regard to race. And remember, these were people who had lived their lifetimes in rigid segregation. The New York Times suggested that the Johnson administration ought to make up its mind. Did it want to supply medical services in the South or did it want hospital integration? The administration, it argued, clearly could not have both. But in fact we did get both, just about everywhere.

— Ball, R.M., 1998

Over the past 30 years, Medicare has helped to redefine the normal expectation of aging in America as a dignified, actively independent stage of life for all Americans, rather than economically deprived dependency. Now there is a question as to whether the cloak of dignity is slipping, or how nice a cloak America can (or wishes to) afford. Despite Medicare's contributions, there are still problems in access to and quality of health care for some in the beneficiary population. Elders living in poverty are still more vulnerable to conditions and health problems that may lead to permanent limitation associated with, for example, diabetes, asthma and high blood pressure. Evidence continues to show that lower socio-economic status is associated with less preventive care and poorer outcomes with respect to entry into the health care system, diagnosis, treatment efficacy, follow-up and readmissions (Cassel and Siegel, 1998). There is also clear evidence that differences among racial and ethnic groups in the utilization of Medicare services, including some important medical technologies, have persisted, and in some areas appear to have widened (McBean and Gornick, 1994; Cooper et al., 1996; Ford and Cooper, 1995; Lee et al., 1998; see Chapter 1). Research has not clearly identified the causes for disparities in the utilization of health services, and in health care outcomes. Barriers to access such as lack of supplemental insurance and high out-of-pocket costs, lack of facilities and practitioners in inner-city or rural areas, inadequate transportation, and cultural and linguistic barriers to effective communication between patients and practitioners have all been posited as possible factors (Gornick, et al., 1996; Cohen, et al., 1997). Whether Medicare will be capable of playing a leadership role in addressing these sorts of problems will depend on how any reforms affect the roles and responsibilities

of the government in administering the program.

CONCLUSIONS

People disagree about the role of government and the role of markets in modern society, and about whether social insurance fosters a concept of social obligation across generations in an aging society. There may be disagreement about whether fostering mutual responsibility across generations through social insurance programs is politically important in itself, and how far global and national economies need to depend on a base of income protection and health insurance. In the case of Medicare, however, the Study Panel believes these larger philosophical questions need not and should not be at issue. The private market was never able in the past, and is not now able to offer a product than can adequately address the health insurance risks of the nation's elderly and disabled populations at a price that most can afford. Medicare premiums for those buying in to the program are about $4,300; if current beneficiaries had to buy that insurance, at that price (which reflects no profit to the insurer and very low administrative costs), it would cost a third of all elderly couples at least half of their family incomes. And that insurance would not cover all their health care expenses, since even with Medicare, beneficiaries are still spending, on average, almost a fifth of their family income out-of-pocket for health care.

No current reform proposal starts by assuming that medical care should not be provided to the elderly and disabled. As the evidence presented in Chapter 1 suggests, most of the increases in Medicare costs are a function not of the aging of the population, but of increases in the intensity and costs of medical care. Breaking the intergenerational links in Medicare financing might address perceived problems of equity among cohorts, but would not solve the long-term financing problem, since each cohort would have to face the issue of what to do about rising health care costs. Moreover, dividing the problem into smaller pieces could generate serious problems of equity. For example, each cohort may face very different health cost risk. One cohort may find that a new medical breakthrough that can prolong healthy, active life for hundreds of thousands of individuals comes at a very high price. Ten years later that same treatment may cost one tenth as much. Or a new technology may become available to completely control the symptoms and disability caused by an otherwise devastating disease, but its cost could not have been foreseen when that cohort was putting away money for its retirement health insurance needs. The benefits one cohort might enjoy could be beyond the means of another. Would this be regarded as fair?

The debates over cohorts and generations, stimulated by Medicare's structure as a public program largely for the elderly, mask more fundamental questions about health care in general. Indeed, the general increases in health care costs that are depleting the Medicare HI trust fund are also threatening the viability of private health insurance as the foundation of health care coverage in the United States, making it unaffordable for a large and growing number of working people and their families. Dealing with long-term problems related to health care costs will affect all Americans. At some point, directly or indirectly, decisions will have to be made about whether there are acceptable limits on necessary and appropriate health services and on the costs of services, not just for Medicare

beneficiaries, but for everyone with health insurance. Doing this fairly and effectively will, the Panel believes, require building a strong political and social consensus across all age groups.

After reconsidering the risks Medicare was created to address — risks related to longevity, health, the structure of insurance and economic markets, and the unpredictability of the nature and costs of health care technology — the Panel affirms that the basic social insurance principles of Medicare remain sound and socially beneficial. Medicare cannot provide the health and financial security we have promised to all of our elderly and disabled citizens and their families in any formulation other than social insurance that spreads the risk of health care costs across generations.

The Panel considers Medicare's other social roles to be politically and socially important. Public goods such as graduate medical education and support of disproportionate share hospitals, however, need to be addressed as separate, generic public policy issues, rather than as part of the debate about the future of Medicare. The Panel believes, however, that Medicare's role in the larger health care system needs to be reexamined in the changing context of health care financing, delivery, and organization that have taken place over the past thirty years. In some ways Medicare has been peculiar. While it has shaped, and often led, the private sector by fostering innovation and research in many areas, the program has remained traditional, even stagnant, with respect to its own beneficiaries in critically important ways. Most Medicare beneficiaries have remained in the fee-for-service system even as this has largely disappeared for working Americans, and this appears likely to be true for the foreseeable future. As the rest of the health care system struggles to make managed care work better, Medicare is struggling to administer the fee-for-service program largely under the same restrictive terms Congress set for it a generation ago.

If Medicare is to be accountable to the public and to its beneficiaries, it has to be able to manage health care — as the private sector has tried to do — but with a much clearer focus on serving the needs of the beneficiary population, rather than just cutting costs. The Panel urges policy makers to recognize that Medicare needs be a major participant in efforts to determine what works well in medical care, which technologies are most effective, and how health care providers can be organized and paid to encourage efficiency and quality in the delivery of Medicare services (Brown, 1998). That will require a significant investment from Medicare in research and in infrastructure to support collaboration and experimentation with, and in oversight of the health care it finances. Private health insurance companies budget for effective management, innovation, and research as well as costs of doing business in the health care industry, such as risk management and utilization review. Determining how to reinvent Medicare so it can make use of comparable management tools should be part of the debate about the future of the program.

Chapter 3:
The American Public Views Medicare

Decisions about the future of Medicare will be political ones, made by legislators who keep a keen ear tuned to what they hear constituents saying. The political choices that are made may reflect, but more certainly will have consequences for, the way in which the program will fit into (and shape) America's social and political fabric for coming generations. To think about what Medicare should be in the future, the Study Panel wanted to understand what the American people know, and what they value, about Medicare. This chapter analyzes Americans' views of Medicare as expressed in polls and qualitative research, including a national poll and a series of focus groups conducted under the auspices of the Panel.

We begin this analysis with the caveat that public opinion polls can be unreliable, biased or otherwise inept, and therefore a flawed source of information for policy making when taken alone. Qualitative attempts to characterize public opinion, based on anecdotal evidence, or more systematic reports of structured interviews or focus groups can also be misleading. Understanding public opinion is, however, necessary because it can inform policy makers about what they need to do when they craft reform proposals and when they present them to the public. Medicare is a complicated program, and there is no reason to expect that the public will be able to, or should be expected to, sort through the issues surrounding Medicare reform and formulate workable public policy solutions. If done well, however, public opinion research can provide insight into what people believe is important, and what they worry about, and where they might be vulnerable to misinformation. Knowing what the public cares about can help those who think they know how to design better policies avoid public backlash, often based on a misunderstanding of the facts, that can derail potentially beneficial reforms.

The chapter first reviews attitudes about Medicare in general. The central observation is that Medicare is a very popular program. This popularity is rooted in the public's understanding that the program serves a vital role in the well-being of the elderly and people no longer able to work because of disability, and in the well-being of their families too. Support for Medicare extends far beyond its beneficiaries. People are acutely aware of the failings of the health insurance market for those who may need medical services the most (including themselves, if they have no health insurance, and their families when they become old or if they become disabled), of the high costs of health care, and increasingly, of the need for quality of care oversight and consumer protection. There is far less unanimity of views about how the program actually works or what to do, if anything, to reform it. Our review finds that people are often perplexed by the intricacies of Medicare's administration, coverage and payment policies, and they are skeptical about the ability of the federal government to administer much, including Medicare, efficiently or effectively. The public's understanding of the Medicare reform options now under consideration reflects both deeply held values about government and personal responsibility, and misperceptions about the

basic organization and workings of Medicare as well as the details of coverage and benefits. Opinions about specific options for restructuring Medicare, illustrated by views we heard in a series of focus groups conducted with beneficiaries and soon-to-be beneficiaries in early 1998, do, however, indicate a strong interest on the part of "average" Americans in having the information they can use to help them understand the substance, and the implications, of major policy changes.

MEDICARE IS IMPORTANT TO AMERICANS

> *"I was wondering what happens to people that have an illness, and they shop around, and no insurance company will cover them because they've had an illness already…so they end up having to pay way beyond what they can afford, because they are already sick, and nobody covers them?"*
>
> —NASI focus group, non-beneficiary

Most Americans think that Medicare is important to the health and economic security of beneficiaries and their families. Health care costs can be terrifying. A 1996 poll fielded for the Employee Benefits Research Institute found that Americans were more worried about paying for their health care after their retirement than about covering their basic living expenses (Bowman, 1998). A national poll conducted in 1996 for the American Association of Retired Persons found that 83 percent of people aged 65 or over agreed that Medicare makes it possible for them to remain independent; 61 percent "completely agreed" with the statement "Without Medicare most Social Security payments would go for health care." Few of the adults polled believed that the private market could work for seniors. Younger people were more likely to believe that the market could work than were older people, but even among those aged 18-29, only 25 percent believed that private insurers would sell health insurance to people aged 65 or more; 26 percent thought seniors would be able to afford it. Over half (52 percent) of those aged 30-49 expressed complete agreement with the view that "older people would really suffer in terms of financial security without Medicare" and the same percentage completely agreed that they were "glad to have Medicare because taking care of parents is too much of a burden without Medicare" (DYG, Inc., 1996).

> *"It's there when you need it… Security. Kind of safety-net like…*
>
> *Our health is protected by it. I feel secure."*
>
> *"For me, it is a benefit because when one needs Medicare, it is there."*
>
> —NASI focus groups

Support for Medicare reflects some strongly-held values about the role of government and personal responsibility. The NASI poll conducted in Spring, 1997[1] found that a clear majority (83 percent) agreed that the federal government has a basic responsibility to guarantee that the elderly and disabled have adequate health insurance. People under 30 were somewhat more likely to agree that the federal government has a basic responsibility (57 percent strongly agreed; 32 percent

1 The poll is described in Appendix B of this report.

agreed) than were respondents 65 or older (54 percent strongly agreed; 23 percent agreed). In a Kaiser Family Foundation / Harvard School of Public Health survey conducted in late summer, 1998, 77 percent of respondents age 18 and over stated that it was "very important" to them that Medicare be preserved as a health care program for all people when they retire, and an additional 18 percent stated it was "somewhat important." (Kaiser Family Foundation, 1998)

Americans have in fact regularly expressed strong support for health care as a basic right for everyone, not just the elderly or disabled. Gallup polls sponsored by the Employee Benefits Research Institute from 1990 through 1993 consistently showed that a majority believed that the federal government should guarantee health insurance for all Americans.[2] More recently, a 1998 *Wall Street Journal* report showed strong majorities supporting initiatives to provide the same comprehensive benefits package to everyone, to charge the same for health care regardless of health or wealth, and guaranteeing everyone coverage regardless of health or employment. A survey done for NBC News and the *Wall Street Journal* found that support for such policies was as high or higher than it was five years earlier (Hunt, 1998).

> *"Everybody should be covered medically. In other words, what I see as the main point is not only because of medicine and health, but our nation was created in order to create a population that has stability and security, You don't compete within medical practice, because the medical practice is a public service, and the government is responsible and obliged to see that it is a public service, and not a competitive enterprise."*
>
> —NASI focus group

In the wake of public concerns about health insurance and managed care, polls have also found majority support for a government role in the health care market. The national survey conducted for the National Coalition on Health Care in early 1997 found that 72 percent completely agreed or somewhat agreed that the federal government can play an important role in making health care more affordable, and 69 percent said that government can play an important role in making health care better; in contrast, 40 percent agreed with the statement that the government should stay out of health care altogether, compared to 57 percent who disagreed (International Communications Group, 1997).

At the same time, Americans' support for Medicare also reflects values about individual responsibility, and the *earned* right to coverage.

> *"You naturally think of a person that has worked all their life, and that person is retired, and receiving the benefits…You've worked, you've worked for it, and paid into it."*
>
> *"They have to care for you after you get 65, because you worked, and you paid in all this money to Medicare, and so you expect, you know, to get*

2 The Gallup/EBRI poll asked "Do you think the federal government should provide health insurance to all Americans?" The answer was "yes" among 56 percent in 1990, 60 percent in 1991, 63 percent in 1992, and 58 percent in 1993. For a discussion of these surveys, see Jacobs, L.R., and Shapiro, R.Y., "Public Opinion's Tilt against Private Enterprise," *Health Affairs* (Spring (I) 1994): 285-298.

help whenever you get 65 and retire."

"When I was young I complained about the money that was deducted from my check and how I never had as much as I wanted, but now I'm happy with everything that they are giving to me."

"I also complained when they took so much money away from me but now with all the benefits I have I realize now that I am doing well because of all the money they took from me."

—NASI focus groups

The NASI poll found that 19 percent expressed strong agreement, and 30 percent agreed somewhat that "Individuals should be responsible for setting aside enough money to pay for their own health care expenses after they retire" (17 percent disagreed somewhat, and 28 percent strongly disagreed; 6 percent responded "don't know"). This finding appears consistent with earlier polls that have found that Americans place high value on personal responsibility, but also believe that everyone should have access to health care, regardless of their ability to pay. In nine National Opinion Research Center General Social Surveys conducted between 1975 and 1991, about one third of respondents agreed strongly that it is the responsibility of the government to help people pay for doctor and hospital bills *and* that people should take care of themselves (Jacobs, Shapiro, and Schulman, 1993).

"Our health care should be our number one priority…[We] don't have too much income, but manage to do everything else we want, so why not, if it's a few pennies more on Medicare, pay that, and think nothing of it, because listen, if you get in a predicament where you need these services, it's there for you. And you can always be proud, 'I'm so glad I paid a few more pennies.'"

—NASI focus group

There is convincing evidence that Americans do in fact view Medicare as a "social contract" that must be honored. The DYG, Inc. poll conducted in 1996 found virtually no difference in the proportion of retirees (76 percent) versus nonretirees (77 percent) who expressed agreement or strong agreement with a statement that Medicare represented a "commitment made a long time ago that cannot be broken."

Americans consistently rank Medicare as a policy priority above practically any other government initiative or program. In 1996, a survey for the Cato Institute found that 72 percent of respondents had a favorable view of Medicare (McInturff, 1996). A 1994 national poll found that three fourths of Americans consider the Medicare program important to their own families (Blendon, 1995). A *NBC News/Wall Street Journal* poll of more than 2000 adults (December 1997) reported that 51 percent of respondents believed Medicare was "very important" to them personally (Hart and Teeter, 1997).

"[T]he government should find the means to ensure that the program continue…if they [our grandchildren] were not able to afford anything else, that at least Medicare was there…"

"…Tell them [our grandchildren] the importance of getting this, and working toward getting this, because, well, just plain tell them, 'One day you may need it'…"

—NASI focus groups

THE PUBLIC'S VIEW OF THE "MEDICARE PROBLEM"

Americans have been concerned about Medicare for much of this decade. By 1995, polls showed that 80 percent of Americans believed the program had financial problems, and about 60 percent believed the problems were "serious". To put this level of concern in context, prior to the 1996 elections, Blendon and colleagues compared the percentage of people reporting that they were following the debate about Medicare closely to the percent following other major news stories: In September, 1995, more people said they were very interested in the debate about Medicare (31 percent) than in any other major news story, including the debate about welfare reform (24 percent) , the O.J. Simpson trial (23 percent) or the federal budget debate (20 percent) (Blendon, 1995). In 1998, the Kaiser / Harvard survey found that 62 percent agreed that the Medicare program was headed for a crisis, or that it had major problems, but was not headed for crisis (Kaiser Family Foundation, 1998).

Following the 1996 Presidential election, concerns about Medicare were clearly in the public's consciousness. A Kaiser-Harvard survey conducted in November, 1997 found that only 14 percent of adults not currently covered by Medicare thought they would get most of the benefits that people who were current beneficiaries receive. Fifty percent thought they would get some, but not all of the benefits, and 30 percent said they expected to get none of the benefits (Kaiser-Harvard Program, 1997). To some extent, this pessimism might be attributed to intensity or to the tenor of the election campaign rhetoric. The NASI poll, conducted 5 months later, found that 13 percent of the respondents under age 65 thought that, twenty years in the future, eligible people would get most of the benefits currently provided by Medicare, 60 percent thought people would get some of the benefits, and 25 percent thought future beneficiaries would get none of the current benefits.

The 1997 *Washington Post* / Kaiser / Harvard Survey Project reported that 69 percent of Americans believe the Medicare program was likely to go bankrupt at some point in the future. Less than one in four of those polled, however, believed that the program was "in crisis". As legislation to balance the U.S. budget was being hotly debated in the spring of 1997, the poll found that 77 percent opposed reductions in Medicare and Social Security to balance the federal budget; the only circumstances that would warrant cutting Medicare spending, according to that poll, would be if the cuts were needed to keep Medicare from going bankrupt (Blendon, 1997).

> *"[I]f things continue in that manner there will be fewer people paying for the retirement of older people. If things do not change and they continue as they are, life will be very difficult for our kids."*
>
> —NASI focus group

THE PUBLIC'S UNDERSTANDING OF MEDICARE

The Medicare program is phenomenally complicated. The law and regulations governing coverage, benefits, payments, participation by provider organizations and practitioners, beneficiary rights and appeals, and so on provide full-time work for large corporate Medicare policy staffs and their consultants and attorneys. Individual Americans have problems understanding

both the basic structure of the program and abstruse paperwork issues related to paying bills. The expansion of new Medicare managed care options, private contracting, and medical savings accounts undoubtedly is raising the level of confusion and anxiety about what Medicare is and what it does.

The public's understanding of Medicare's insurance provisions is limited (Institute of Medicine, 1996). The 1998 Kaiser / Harvard survey and Blendon et al.'s review of data from 1994 and 1995 found that the public as a whole was not well informed about Medicare benefits. In the earlier polls, most (77 percent) knew Medicare was a program run primarily by the federal government, and that it paid physician bills for people aged 65 or older (75 percent), but many were unclear about what benefits are actually covered by the program. In both the 1995 and the 1998 polls, most Americans not yet on Medicare did not know that Medicare does not pay for long-term nursing home care or outpatient prescription drugs. Predictably, Medicare beneficiaries are far more likely to know what Medicare pays for than are non-beneficiaries, but more than one in five of the respondents aged 65 or older thought that Medicare covers prescription drugs and pays for long-term nursing home care in the 1998 Kaiser / Harvard survey. Medicare financing is poorly understood; less than one third of 1995 survey respondents knew that there were different funding sources, including both a separate trust fund and general budget funds paying for Medicare (Blendon, 1995).

There is not much evidence about what the public knows or thinks about the ancillary functions Medicare has taken up in the areas of supporting graduate medical education, providing additional payments to hospitals serving the uninsured and hospitals in rural areas, supplying data and institutional support for research, etc. In work conducted for NASI, however, Michael Gusmano and Mark Schlesinger report on a set of five focus groups with seniors in the New Haven, Connecticut area to discuss these programs. Not surprisingly, beneficiaries did not know the specifics of these programs. However, when graduate medical education payments, uncompensated care and rural provider payments were explained, and information on the costs of these programs was presented, most of the seniors expressed the view that these program were in fact important, and should be continued.

Dealing with Medicare fee-for-service has always been confusing to beneficiaries and those helping them with claims. A survey conducted by the Physician Payment Review Commission in 1989 found that about nine percent of beneficiaries had paid bills themselves rather than attempting to file claims (PPRC, 1989). Among those stating they had not filed claims for bills of $75 or more, the most commonly cited reasons were that filing the claim was too complicated or time consuming. Even with the direct submission of claims now required of all providers, beneficiaries can still be caught in complicated billing problems related to denials or partial denials of coverage, sorting out Medigap claims, etc.[3]

3 In 1997, for example, appeals were filed in less than one percent of claims, but this added up to over 6 million appeals. The largest number of appeals relate to claims submitted for physician and other services under Part B. Most of these are resolved at the contractor (carrier) level. The contractor ruled in favor of the appellant in 70

Managed care presents an entirely new kind of complexity. A survey of Medicare beneficiaries conducted for AARP in late 1997 in five areas of the United States with high levels of HMO market penetration found that most respondents had limited knowledge of the differences between managed care and fee-for-service plans (Hibbard and Jewett, 1998). A significant proportion of NASI focus group participants in California (more than half in some of the focus groups), where managed care is far more established than most other parts of the United States, did not know if they were in traditional, fee-for-service Medicare or not. There were a number of stories about problems individuals had when they had gone to out-of-plan providers, either because they did not understand the managed care rules, or because they felt that they could not wait to see an approved provider. Some participants thought that they were NOT in Medicare at all if they were in an HMO; some believed that the $43.80 withheld from their social security checks for the Part B premium was the full payment for HMO services, and that Medicare therefore was not paying anything toward their insurance. Most beneficiaries do not know what their health insurance actually costs.

> *"I'm confused because I have Kaiser too, and I have Medicare, Part A and Part B, and I don't know what it does for me, What does it do? I know it makes the premium lower for Sierra College to pay. But I go to Kaiser, so everything is there, I don't know what Medicare is doing, except giving Sierra College money for my Medical treatment at Kaiser."*
>
> *"I wondered what Medicare was in, other than that we had to sign our Medicare over to the HMO…"*
>
> —NASI focus group

Because they thought they were no longer in Medicare, some were convinced that they had to deal with the HMO entirely on their own — they did not know that Medicare HMO beneficiaries have a right to due process established in Medicare law and regulations, and consumer protections that can be enforced by the Medicare program.

> *"…you can't keep both of them [Medicare and HMO enrollment]. I was explaining to the lady when I talked to her about Medicare, I said just about everyone you have is going to have an HMO. There is an HMO that replaces Medicare, but there are still people on Medicare. Especially people on SSI, they're all under Medicare, but then there's a difference in your doctors, like waiting service…"*
>
> —NASI focus group

Beneficiaries who were also eligible for MediCal (Medicaid) were confused about what benefits they could actually receive. This was a serious problem for some beneficiaries who said they could no longer get prescriptions that they had been getting under MediCal through their HMOs. One told us she was no longer taking all the pills her doctor prescribed, because she could not get them through her health plan.

---

percent of the 3,337,592 cases involving 5,811,740 Part B claims for which reviews were completed in 1997 (Hash, 1998).

"When I ordered my pills this last time [through the HMO pharmacy], I couldn't get them in there, because I was only allowed four [of six prescriptions]. I don't know. But I'm nothing, I'm just, you know, Medi[care]-Medi[Cal]…"

—NASI focus group

PUBLIC OPINION OF MEDICARE REFORM OPTIONS

Given the complexities of the program, assessing the public's views about potential changes to Medicare is problematic. An examination of polls and survey research by the Academy and by other organizations indicates that there may be some areas where there is reasonable consensus among the American people, but there are areas where concepts of what makes sense, or is fair, may be confounded by lack of understanding of how Medicare operates, or what the proposed reform actually entails.

The poll conducted by the Academy in the late spring of 1997 asked for views on seven possible ways to address Medicare's impending trust fund problem. One thousand respondents from 48 states were asked what they thought about public and individual responsibility for health insurance, and about Medicare reforms. The sample was split evenly among men and women; nineteen percent were Medicare beneficiaries. Policy options were not posed as specific legislative proposals, but rather as general approaches to addressing the long-term funding problem. The poll results, along with the introductory statement of the problem being addressed by the reform options,[4] are summarized in Table 1. As discussed below, these results are generally consistent with those of other polls conducted around the same time. There are, however, some differences across the polls, and differences among subgroups of respondents that raise some questions about what the polls can really tell us. The discussions we heard in the focus groups conducted in 1998 provide additional insight into what people think about Medicare.

In the focus groups conducted by the Academy in the winter of 1998, the discussion of Medicare reform was structured around four broad approaches: reducing Medicare costs; adding more money to the program; increasing costs to beneficiaries, and changing Medicare to look more like present-day private or employer-sponsored health insurance. Within each topic, a number of options were discussed.

Cutting Costs

In the 1997 *Washington Post* / Kaiser / Harvard survey, 83 percent of the respondents cited excessive charges by doctors and hospitals as a major reason why Medicare is facing a financial problem (Blendon, 1997); in the 1998 Kaiser / Harvard survey, 73 percent said excessive charges were a major reason for Medicare's financial difficulties (Kaiser Family Foundation, 1998). But while polls have shown a generally positive response to proposals to save money in Medicare by reducing payments to hospitals and physicians, there is also evidence that there is an underlying apprehension about reducing payments too much. During the 3-month period prior to the 1994 elections when Medicare was being hotly debated, a set of national opinion

4 The survey was conducted prior to the passage of the Balanced Budget Act of 1997. With the 1997 changes in the Medicare program, the Trust Fund is expected to remain solvent until 2012.

NATIONAL ACADEMY OF SOCIAL INSURANCE—MEDICARE SURVEY, MAY 1997

The Medicare program currently provides health insurance coverage to 33 million persons aged 65 and over, and 4 million people with disabilities. Medicare's Trust Fund that pays for hospital care for the elderly is currently projected to run short of money to cover costs in about 10 years. Would you favor or oppose the following steps to fix the Medicare program:	Total Favor	Strongly Favor	Somewhat Favor	Don't Know	Total Oppose	Somewhat Oppose	Strongly Oppose
Reducing payments to hospitals, doctors, health care plans, and other providers	63%	34%	29%	6%	32%	15%	17%
Adding money to Medicare from new taxes or general government funds	58%	30%	28%	6%	37%	15%	22%
Making more beneficiaries enroll in managed care organizations, like HMOs, that limit your choice of doctors or hospitals in order to provide services more efficiently.	44%	19%	25%	6%	49%	18%	31%
Replacing Medicare with private sector health insurance for the elderly and disabled	42%	17%	25%	11%	47%	15%	32%
Raising the age when you start to get Medicare benefits to 67 or even higher as lawmakers have planned for Social Security	31%	13%	18%	3%	66%	16%	50%
Making Medicare beneficiaries pay more for it from their Social Security checks	25%	7%	18%	4%	70%	20%	
50% Reducing Medicare benefits by covering fewer services	21%	7%	14%	5%	74%	23%	51%

Source: National Academy of Social Insurance survey, 1997

polls found that the proportion of Americans who supported cutting payments to hospitals and physicians fell from 67 percent to 54 percent. According to Blendon, et al., (1995) this appeared to reflect fears that if Medicare reduces payments, hospitals or physicians might refuse to treat beneficiaries, or might shift costs to younger, privately-insured people. In the 1998 Kaiser / Harvard survey, 47 percent favored, and 48 percent opposed reducing payments to doctors and hospitals (Kaiser Family Foundation, 1998).

In the Academy's focus groups, the interplay of several views played out quite consistently. In both the beneficiary and non-beneficiary groups, there was a strong perception that provider reimbursement was sometimes unreasonable and excessive.

> *"I went to the hospital for just two or three days, and they charged me a lot of money. They actually charged me more than $15,000, and that's crazy."*
>
> *"Moved me three blocks and they charged me $7,000."*
>
> —NASI focus groups

At the same time, there was a clear concern in every focus group that cutting payments to providers could lead to reduced access to care and quality of care problems.

> *"I was thinking that we cut their income, why it would be an incentive to not do as good. They'd think, 'Why should I bother about this,' if you cut their income."*
>
> *"I don't believe that they would refuse to serve you, but I don't think you might get the quality of service that you need…"*
>
> *"…I just think that if we want good care we have to pay for it."*
>
> *"Well, if you're not paying the doctor…he might say 'Well, I'm not getting paid what I'm worth,' especially if he's a specialist…like a heart specialist, and he might not want to take enough time with his patients to look for something that's there, and the hospitals might cut down on doctors and nurses, and you wouldn't get the care that you need there…"*
>
> *"If we pay doctors less we will be stuck with the worst doctors and the youngest doctors because all the doctors will go practice somewhere else."*
>
> —NASI focus groups

There was also a view, expressed in several the groups, that physicians deserve to be paid well.

> *"…[W]e have to remember that they have a staff they have to pay…"*
>
> *"They spend a lot of time in school to make that money, and I think they deserve a lot of it."*
>
> *"It takes a long time to go through medical school and internship, and a specialty…somewhere along the line you may or may not have kids to put through school and graduate school, etcetera, etcetera, so I don't think that paying doctors less is the answer."*
>
> *"Like I said, It's free enterprise… everybody should be compensated."*
>
> —NASI focus groups

In discussions, the California focus group participants were able to articulate an important distinction between excessive and / or inappropriate health care costs for some

health care services and the need for fair compensation for quality medical care. What Medicare needs to do, said one participant is, *" not so much to pay them less, but to make them more efficient."* In most of the groups, there appeared to be strong agreement that a lot could be done to help both practitioners and the population in general make better decisions about when to use health care. There was also strong agreement, consistent with national polls (DYG, Inc., 1996; Blendon, 1997; Kaiser Family Foundation, 1998) that fraud and abuse is a serious problem that costs the Medicare program a lot of money. Many participants had read headlines or heard television exposés about health care fraud. The participants were not, however, sure that the problem was a Medicare problem *per se* — people also believed that fraud and abuse was pervasive throughout the health care system. In several groups, participants also noted that individuals should be willing to do something about excessive or fraudulent practices.

> *"…[A] lot of people don't pay any attention to it, but we do get, from time to time, we do get a letter from Medicare wanting to know whether the charges that the doctors have been charging are legitimate charges. And if we, when we get those letters, if we respond to them, then they would have information about it."*
>
> *"We have to be more aware of what's going on."*
>
> —NASI focus groups

The public has expressed consistently high levels of opposition to proposals to reduce Medicare outlays by increasing the age of eligibility for Medicare, in tandem with increases in Social Security retirement age. Polls conducted by the Kaiser Family Foundation (August-September, 1998), LA Times[5] (September, 1997), Gallup[6] (June 1997), and The Pew Research Center for The People & The Press (June 1997), like the NASI poll, found virtually the same proportion of Americans, about two-thirds, opposed to the increase. In the focus groups conducted by the Academy there was support both for and against this option. Some participants expressed the view that raising the age was not fair, i.e. "violating the contract." Others were worried that older people would not be able to get health insurance, particularly those who are no longer working when they are in their 60's, either because they have chosen to take early retirement, or have been forced out of the labor market because of downsizing (a significant issue in the California defense-related industries), or because of health problems (which may or may not provide eligibility for Medicare through the disability determination process).

> *"[A]bout the 67 — they should leave it alone, because, you know, I'm paying that, and 65 is what I was paying for…when I look at my check, and I see that they've taken as much out in Social Security and Medicare taxes as they did, and taxes, they'd better pay me."*
>
> *"…I've worked 33 years. I'm not near 67 yet, and then something happens to me, if I didn't have Kaiser or something, and had to*

5 Peterson, 1997.

6 Moore, 1997.

wait until I'm 67 years old? I mean, that's ridiculous."

—NASI focus groups

In most of the groups, however, participants also talked about how people were living longer, healthier lives. For people who are healthy and who have jobs, the increase seemed like a good idea, if it would help save money for Medicare.

"I think we should raise the eligibility age to 67 in order to enable the next generation to have the same kind of medical services we do, Secondly, the young people today are stronger than we ever were at the same age."

"Knock on wood, I hope we're healthy at 67 and don't have to worry about that, but if you are looking for a way to reduce the costs, then I might be in favor if it, increasing the eligibility age."

—NASI focus groups

Increasing Revenues

Polls have generally shown that the public has mixed feelings about increasing revenues through payroll tax or other tax increases. Responses to questions about raising revenues appear to be particularly sensitive to the wording (or nuance) of questions, as well as to the immediate political climate. In the NASI poll (May-June, 1997), 58 percent favored or strongly favored adding money to Medicare from new taxes or general government funds, but a December 1996 *NBC News/Wall Street Journal* survey found that only 42 percent approved of raising the Medicare payroll tax to shore up the program (Hart and Teeter, 1996). In the 1998 Kaiser / Harvard, 64 percent opposed an increase in Medicare payroll taxes (65 percent of those under 65, and 58 percent of those 65 and older). A survey by the Concord Coalition conducted in 1995 asked about doubling the current payroll tax "to allow Medicare to be fully funded and elderly Americans to continue to draw all the benefits they do now"; just over 50 percent approved of the increase, while 46 percent rejected it (Bowman, 1998). The same year (1995), a Henry J. Kaiser Family Foundation / Harvard School of Public Health / Louis Harris and Associates poll reported that 32 percent of respondents favored raising the Medicare payroll tax. Blendon et al. (1995) also reported that 24 percent of those polled said they would pay higher taxes to preserve current Medicare benefits and 28 percent said they would pay even higher taxes to provide additional benefits, while 42 percent would accept more limited coverage rather than pay higher taxes.

Some of the variation may relate to the context set out in the polls, as well as the precise wording of the questions. Views about raising payroll taxes are tempered by views about taxation in general, and about the causes and the severity of Medicare's fiscal problems. Some polls have shown, for example, that many people believe that if fraud and abuse were "eliminated" from the Medicare program, there would be no need for additional funding to secure the program (DYG, Inc., 1996; Lake, 1998);[7] others suggest that people may believe that better administration or

7 The best available estimates are that in fiscal year an estimated that between 7 and 16 percent of Medicare payments were improper, i.e. were not fully or correctly documented, or were found to reflect possibly questionable, abusive, or fraudulent practices; only a portion of these were thought to reflect actual fraud and abuse (U.S. Congress, GAO, June 1, 1998).

management can solve Medicare's problems, without any need for additional revenues or adjustments to coverage or benefits.[8] When these issues were discussed at some length in the NASI focus groups, it became clear that people understood the need to think seriously about options that might require some sacrifices on their part.

For some focus group participants, increasing payroll taxes seemed to be entirely reasonable:

> *"Don't you think that the young people that are working now would want an increase on their Medicare? Let's say two or three percent, or no higher than five. [W]e used to invest five percent of our salary, for the future, so that would be their future, so they could have their Medicare when they got ready."*
>
> *"If they realize it's going to save the system, I don't think the person that's young would object to pay a little more."(Non-beneficiary)*
>
> *"I think everybody in this room feels that people that are collecting it now paid their dues. We paid our dues, But maybe the younger people, because it's going to be a more expensive plan 20, 30 years from now, should pay, and should start contributing a little more to balance it. …I lean towards seeing an age limit lying between there, I don't know whether it's forty or fifty, but I do feel like maybe there should be additional costs to those, the younger people in the workforce that are going to be going into this benefit." (Non-beneficiary)*
>
> —NASI focus groups

For other participants, particularly those on Medicare who had grown children still struggling to make ends meet, payroll tax increases seemed unfair. Some also pointed to people who had not paid into Medicare, e.g., recent immigrants who receive Supplemental Security Income payments and are "bought into" Medicare through Medicaid, who are able to get Medicare benefits (this may be a phenomenon that is particularly salient in California).

> *"The people that are working would resent that [higher Medicare payroll taxes]. They are paying more in now than we ever had to pay, even when we were working, and I think they wouldn't like it at all."*
>
> *"It takes two jobs now for a family to keep things going without raising that."*
>
> *"Imagine, requiring someone who makes the minimum wage to pay more taxes. Taxes should not be raised for those earning the minimum wage…They barely have money to survive."*
>
> *"They [younger workers] can't get along on their own anyway, let alone supporting somebody else. I don't think we should expect them to support us. That's our responsibility. It should be." (Non-beneficiary)*
>
> —NASI focus groups

8 The 1998 Kaiser/Harvard survey found that 75 percent said that even if all the fraud and abuse in the Medicare program could be eliminated, this would not be enough to fix the program's financial problems; in that poll poor management by government, excessive charges by doctors and hospitals, and medical cost increases in general were cited as major reasons for Medicare's problems more often than fraud and abuse (Kaiser Family Foundation, 1998)

In most of the groups, other approaches to increasing revenues, such as "sin taxes" on tobacco or alcohol were viewed more favorably. In several of the groups, participants also talked about the advantages of broad-based taxes (either income-related, or general sales taxes) that would be paid by everyone, regardless of whether they were working. It was important to participants who advocated these types of taxes, however, that the money that would be raised be clearly earmarked for Medicare, and protected from the politicians who might want to use the money for other purposes.

Public reactions to proposals to increase beneficiary cost-sharing can also lead to a variety of interpretations. Some polls have found modest support for relatively small increases in beneficiaries' monthly Medicare premiums. One 1995 poll found 52 percent of respondents in favor of a $7.00 (per month) increase in Medicare premiums, compared to 32 percent in another poll expressing support for a $21.00 increase (Blendon, 1995). Opposition to increasing beneficiary payments in the Academy's poll may reflect not only a general concern about making beneficiaries pay more, but a more specific concern about taking money from people's Social Security checks. While this is in fact how premiums are collected, poll respondents may not have known that, which could have made the policy option seem particularly intrusive (i.e. the government taking money from the checks people live on). Nevertheless, the notion of sizable across-the-board increases in beneficiary spending is problematic: when phrased in general terms, as it was in the 1998 Kaiser / Harvard survey, "Do you favor or oppose requiring seniors to pay a larger share of Medicare costs out of their own pockets", 80 percent chose "opposed."

"I get more medical services than my predecessor, you know, years ago, did, and I think I should pay more for the service I get. I would be willing to pay a small increase."

"Those of you that can afford this [increasing beneficiary payments], that's fine. But there are people who can't afford. They need every little penny they can get, We have hungry people right here, today."

"How could you do that… If you only have Social Security coming in?"

"People already do not have enough benefits and if you take money away from them they will not have any money left over for special services like dentistry or optometry."

"Well, you can't do that, because a lot of these people get this little bitty check, and have to live and pay these outrageous rents…These people can't make it now. And you're going to take, even ten dollars out of their check, [that] would kill them." (Non-beneficiary)

—NASI focus groups

The question of beneficiary cost-sharing is intertwined with the issue of income-related cost-sharing. Public reaction to proposals to require higher-income beneficiaries to pay more appears to have shifted over time. Intense opposition on the part of some beneficiaries to income-related premiums for Part A included in the Medicare Catastrophic Coverage Act (1988) contributed to its repeal. By the mid 1990s, however, modest support for income-related payments seemed to be building. In a 1995 poll, over three-fourths of Americans said they favored higher Medicare premiums for beneficiaries with

incomes of over $75,000 per year (Blendon, 1995). When asked to choose among three alternatives regarding who should be able to receive Medicare benefits in the year 2000, 42 percent said benefits should go to all retirees, but that higher income beneficiaries should pay more, while 34 percent said that if people paid Medicare taxes, they are entitled to benefits no matter what their incomes; 23 percent opted for means-testing the program and requiring those with higher incomes to buy their own health insurance (Blendon, 1995). In the 1998 Kaiser / Harvard survey, 64 percent stated that they favored "Creating a sliding scale for Medicare, so that the more money seniors have, the more they pay in Medicare premiums" (Kaiser Family Foundation, 1998).

Legislative proposals to increase cost-sharing for higher-income beneficiaries were introduced in Congress during the budget debates in 1997. The polls taken around that time illustrate some of the problems inherent in using polls to inform policy-making. One poll, commissioned by the LA Times, used very general language, asking , "To keep Medicare solvent, do you favor or oppose making high-income seniors pay more for Medicare?" Twenty-five percent of respondents said they strongly favored the policy, and 19 percent favored it "somewhat" (44 percent "for"); 18 percent opposed it and 33 percent strongly opposed it (51 percent "against"); five percent did not answer (Peterson, 1997). A Pew Research Center poll conducted three months earlier (June 1997) was worded differently, asking respondents about a policy that would "Require individual seniors who make more than $50,000 a year and couples who make more than $75,000 a year to pay a larger portion of their doctors' bills" (Pew Research Center, 1997). The Pew poll thus implied that the additional cost-sharing would be at time of payment, rather than as larger premium monthly premium payments. While 26 percent strongly favored this option and 34 percent reported favored it (60 percent "for") , only 12 percent strongly opposed it, with 25 percent opposing it somewhat (37 percent "against"), with 3 percent not answering.

In the NASI poll, respondents were asked about the concept of income-related cost-sharing from the perspective of values, rather than about a specific policy to implement higher cost-sharing for wealthier seniors: "In your view, should wealthier people eligible for Medicare be required to pay more (for Medicare) than people with lower incomes, or pay the same amount and receive the same benefits as everyone else who paid into the Medicare system?" Forty-two percent responded that wealthier seniors should "pay more," 54 percent chose "pay the same for the same benefits" and 4 percent did not provide an answer. In both the LA times and NASI polls, seniors (65 and older) were more likely to support higher cost-sharing by wealthy beneficiaries than were younger respondents. In none of the polls, including the NASI poll, were respondents told how much revenue would be raised via this option, or given any estimate regarding how effectively this option, or any other option, for that matter, would contribute to solving Medicare's financing problem (see Chapter 4).

In focus group discussions, it became clear that views about the treatment of higher income beneficiaries were confounded by misunderstandings about Medicare coverage. A number of participants believed that wealthy people do not use Medicare, because

they have other, better insurance that they use first. The participants also did not have a sense of what the income level of average beneficiaries is, or how many were "wealthy."[9] As the participants worked through the discussions, however, several different strands of argument generally emerged. There was some sentiment in virtually all of the California groups that people ought to contribute their fair share, and, therefore, wealthier people should pay more.

> *"I think that not all Medicare beneficiaries should have to pay because we don't all have the same income, and we don't all have the same lifestyles, and there is some people who depend on Medicare solely…whereas there's a millionaire collecting Medicare, and he's not paying as much as we are."*
>
> *"[T]hey get a lot of tax breaks, and so forth, and I just believe that when you have more, you should contribute more."*
>
> *"I think there should be a sliding scale to ensure fairness."*
>
> *"I think that the heavier costs should go to the wealthier, because there is a percentage of those people who even though they pay, if they are making six figures, and they have retirement incomes in six figures, and you have someone whose making less than fifty thousand dollars a year, that's not balanced at all. That person can afford to pay maybe ten to twenty dollars a month [more] than a person who is on a limited, fixed type [income]. They can't afford that."*
>
> —NASI focus groups

Another line of argument, however, also emerged in most of the focus groups, but more forcefully in the groups comprised of people aged 50-64. For some, income-relating Medicare is not fair to those who are paying into the program and expect to get full benefits when they become eligible.

> *"I don't think that's fair. I think he's been taxed his 1.45 percent for his ten years plus in the labor force, he deserves everything else that anybody else gets…He actually paid in more, because he had more taxable income…and you are not going to give him the benefit?…let's say, if I felt that if I was going to be wealthy, I wouldn't want to contribute, all through my working career, I'd say, 'forget it, don't take it out of my check, and I won't collect it." (Non-beneficiary)*
>
> *"There would be no incentive if they were going to take it all out in taxes. They'd say…'What incentive is there even to try to save?' So, you can't put all the hardship on the wealthy."*
>
> —NASI focus groups

Restructuring Medicare

Views about proposals to substantially change the Medicare program are particularly hard to gauge. The proposals are complicated and difficult to present in ways that lend themselves to meaningful questions in public opinion polls. Perhaps more important, individuals' opinions about the desirability of major changes are grounded in their own understanding of how the program works now. If people do not understand how

9 In most groups, participants ended up agreeing that they considered "wealthy" to be income levels of over $40,000 to $50,000 per year, but others placed the line of demarcation much higher.

Medicare is organized or financed, it is difficult to assess the implications of change. There are, however, some general issues that underlie reform approaches that are related to opinions and values about the role of government and the accountability of the private sector.

Discussions of basic structural reforms in the NASI focus groups were sometimes confounded by the difficulty of explaining what the reforms actually entail. When the discussion was focused on options that would make Medicare more like employer-sponsored health plans, where people can sometimes choose (based on cost, quality, convenience or other factors important to them) among those plans offered by their employer, opinion among the ten groups in California was definitely mixed. Many of the participants had limited or no experience with choosing among multiple plan options,[10] and the concept of a market-based managed competition system was hard for some people to envision.

Some participants did, however, think a system where beneficiaries chose among competing plans could have advantages.

> *"[Being able to choose among plans] might be a good idea, because, you know, the working [people], or the retirees on a fixed income could choose the lesser plan. Or, if you could afford more, or you're wealthy, then you could afford the better plan, right?"*

> *"[Making Medicare work more like employer-sponsored health insurance] would…give you more incentive…to cut down a whole lot of bureaucracy, all this big government."*
>
> —NASI focus groups

Others were concerned about choice and quality of care.

> *"I know that the companies for which we work are always looking for the cheapest insurance plans, I worked for various companies, my point is that companies are always trying to save money by providing one [plan] with the least amount of coverage."*
>
> *"What if this private industry that you're paying money into goes bankrupt, or is bought out by a large corporation that doesn't have this type of plan, or something like that?"*
>
> *"The public [version of Medicare] would be run by the government overseeing it, that they are working for the public,…[if] it's run as a private business, he's going in there to make money, and he's not going to be concerned about your health care, The cheapest hospital, the cheapest doctor, that's the one he's going to go to."*
>
> —NASI focus groups

Polls conducted in the mid-1990s showed fairly strong support for encouraging Medicare beneficiaries to join managed care

10 Most employers, in California as in the rest of the United States, do not offer employees a lot of choices among plans. The 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey found that, overall, only 17 percent of private employers offer a choice of insurance plans to employees. Few employers (27 percent) provide economic incentives to employees to choose economical plans, and 22 percent provided data on quality of care that employees could use in making decisions about health care plans (Long and Marquis, 1998).

plans as a means of reducing program costs (see Chapter 1 for a discussion of issues affecting the growth of Medicare managed care). A 1995 poll reported that 60 percent of respondents reported being in favor of encouraging more managed care enrollment (Blendon, 1995). Younger people were more likely to favor the proposal, possibly because a large proportion of the employed population is enrolled in managed care. The Academy's poll, conducted in mid-1997, showed some support for moving toward more enrollment in managed care among younger respondents, but, overall, the proportion favoring this approach was substantially lower than in the poll just cited (44 percent favoring more managed care compared to 49 percent opposing it). In the Kaiser / Harvard survey, conducted in late summer, 1998, 56 percent of respondents (54 percent of those under 65, and 63 percent of those 65 and older, opposed the proposal that more seniors be encouraged to enroll in HMOs or other managed care plans (Kaiser Family Foundation, 1998). Growing backlash against managed care in general appears to be affecting opinion about the desirability of managed care for Medicare beneficiaries.[11]

In surveys conducted in the mid-1990s, a clear majority favored keeping Medicare essentially the way it is, run by the government, with a fixed set of benefits (Blendon, 1995). As the topic of "privatization" has moved into the political debates, there is some evidence that people may respond positively to survey questions that pose options which allow people to "have greater control over their own money," particularly if the financial markets are doing quite well. In the Academy's 1997 poll, there appeared to be some support for replacing the federal program with a private system of individual retirement medical savings accounts: 17 percent strongly favored that policy, and 25 percent reported favoring it somewhat (42 percent in all "favoring"), compared to 15 percent somewhat opposed, and 32 percent strongly opposed (47 percent "opposed"). Those under age 30 and those with higher incomes were significantly more likely to favor privatization.

When discussing whether Medicare ought to be replaced with a private system of insurance that would provide for retiree and disabled persons' health insurance, there was also some support among the focus group participants.

> *[Supporting a privatized system] — "You know, because if you look at the government, what they are spending on, you know, toilet seats and ashtrays, and screws and things, you know…I prefer a privatized system because the money is constantly being reinvested."*
>
> —NASI focus group

But participants in most of the groups raised questions about how private management would actually work.

> *"A lot of people may just not know how to deal with this on their own, too. If you work and it's taken out, that's one thing, but they don't have to figure it out how much, and*

11 In a June 1998 survey conducted by Hart and Teeter for NBC News and the Wall Street Journal, 40 percent said that the switch to managed care plans was a change for the worse, compared to 20 percent who said it was a change for the better, and 41 percent said that HMOs have made the quality of health care worse, compared to 16 percent who said HMOs had made quality of care better (The Impact of HMOs, 1998).

what. But there are people of different intelligence, and whether or not they can deal with putting aside, even if it's mandatory. If it is mandatory, it might be a problem because of the paperwork."

"If fraud already exists within the government-run system, I think cases of fraud would be worse in the private system."

—NASI focus groups

Most groups discussed the need for federal oversight and regulation of any sort of privately-administered system, citing examples of bank regulation, transportation, and public utilities. Others couched their concerns in a broader skepticism about how well for-profit organizations could really provide them with the security they want when it comes to health care.

"Your health is something that you want the best guarantee of…They [government regulators] take care of you at the bank, they take care of your health…"

"With the government program, you know that they are going to be around, but with some of these plans, what happens if you privatize it, and this company suddenly can't make it?"

"…The true intent of it [Medicare] eventually will fade away because it will become like any other insurance policy…their [private insurers'] concern is protecting themselves more than they protect the patient…they are in a business to make money, they are not in business to pay it out."

"I trust private less than I do the federal government."

—NASI focus groups

POLICY DIRECTIONS AND PUBLIC OPINION

Public opinions polls and focus groups do not provide very useful guidance or specifics for making public policy, but they do provide some insight into people's values and perceptions. If any one message comes through unequivocally, it is that Medicare is important to Americans. They are concerned not just for themselves but for their parents and grandparents, and also about the burden that an aging population will place on future generations. People also understand that health insurance is complicated, and that reform proposals that focus primarily on controlling Medicare costs could have negative consequences for quality of care and choice of providers. Efforts to change the program are therefore likely to meet with resistance unless the need for change is presented clearly and carefully; people need to be convinced that reforms will not take away the security that Medicare has provided.

Gaps in the public's understanding of Medicare can make the task of sorting through policy options more difficult. At first glance, it appears that people do not like any of the proposed changes to Medicare. Some analysts reviewing the polls are struck by the public's tendency to focus on "easy fixes" that would eliminate Medicare's financial problems by "eliminating fraud and abuse" or decreasing payments to greedy providers or placing a greater burden only on people far wealthier than themselves (Blendon, 1997; Lake, 1998). A close examination of what people say, and of the questions they ask when they have an opportunity, suggests, however, that Americans are neither selfish nor overly cynical about Medicare and its future. When the options are accompanied by relevant information, views can change.

"Having wealthier people pay more" may seem like a relatively attractive solution, but knowing what is meant by "wealthier," what is meant by "pay more" and whether the change will actually do much to shore up the Medicare Trust Fund could change the way in which individuals assess the option.

For many, the overriding issue appears to be "what is fair?" both to those paying taxes, and those who have "paid their dues." People cannot, however, make good decisions about what is fair if they don't know the facts.

> *"You know what, the ones of us who are here now [NASI focus group of Medicare beneficiaries] wouldn't really be involved in that [deciding about Medicare financing], because we are finished working, and we, the ones who depend on Medicare, …it seems to me that we should not choose what the people who are 25 and 30 years old right now [should do]. They should be having a meeting deciding, you know, about their medical care, and if they would like to pay…into something like this for later on."*
>
> —NASI focus group

There are some important parallels between the situation facing Medicare beneficiaries, who are now going to be asked to select from among an expanding set of Medicare "choices", and the public as a whole, who will need to let policy makers know what they think about the array of Medicare restructuring proposals. Beneficiaries have to decide what type of health insurance arrangements — traditional fee-for-service, managed care plans, point-of-service options, preferred provider organizations, provider-sponsored organizations, private contracting arrangements, medical savings accounts — will work best for them in terms of out-of-pocket costs, access to the physicians and services they want and need, convenience and other factors that are important to them as individuals. There is a growing recognition that individual Medicare beneficiaries will likely be overwhelmed by the mounds of information they will need to sort through to make critically important choices about health plans and providers (Kleimann, 1998). When selecting among Medicare plan options, the research indicates, most beneficiaries will not sort through complicated charts and lengthy technical descriptions of plans' coverage, benefits limitations, performance measures, rules, and procedures. People will focus on the specific pieces of information that are important to them and people like themselves.[12]

Similarly, the American public is going to focus on the specific aspects of proposed policies that are important to them — their own health care and financial security, the implications for their family members' incomes and savings, and the wider effects on people like them and the ways in which they interact with others in their communities,

12 See discussion in the IOM's "Assuring Public Accountability and Information for Informed Purchasing by and on behalf of Medicare beneficiaries" in *Improving the Marketplace* (1996); also Enterprises for New Directions, Focus Group Research on Medicare Beneficiary Education, Summary of Videotape Analysis, (Bethesda, MD: July 1991). Submitted under HCFA contract No. 55-90-003, McGee, J., Sofaer, S., and B. Kreling, B., "Findings from Focus Groups Conducted for the National Committee for Quality Assurance (NCQA) Medicare and Medicaid Consumer Information Projects," final report, July 1996, and Frederick/Schneiders, Inc., "Analysis of Focus Groups Concerning Managed Care and Medicare," prepared for Henry J. Kaiser Family Foundation, March 1995.

now and in the future. If they are to judge the alternatives fairly, the public has to have objective information about how the alternatives would work for people like them, and how the structure of benefits and costs to beneficiaries and to taxpayers would change for their children and grandchildren. This kind of information will have to come from a variety of national and local organizations that can reach tens of millions of beneficiaries and their families. Unless the public gains a clearer understanding of the issues and the implications of proposed changes, it is likely that opinion polls will continue to show that the public will not support any major Medicare reform. The challenge for the health policy research community is daunting: generate the information people need to understand what reform options mean, devise ways to package it in ways that people can use, and figure out how to help local organizations get that information to the public. If that does not happen, the best policies and more important reforms could easily be lost in a haze of public confusion and political reaction.

In the final chapter of this report, we return to the principles that have shaped the Medicare program, and we reexamine these principles in the light of the values and concerns of the American public we have just reviewed. Together, these principles and values provide a framework for evaluating options for Medicare reform.

Chapter 4:
Alternative Conceptions for the Future

The complexity of the Medicare program lends itself to many possibilities for reform. Given the pragmatism that dominates American politics (and which has shaped the Medicare program), it is likely that there will be a variety of reform proposals, some incremental, others perhaps more fundamental, presented to the public over the next few years. The precise way in which reform policies are designed and implemented could have very significant, and different, consequences for all beneficiaries, or categories of beneficiaries, over time. Evaluating specific legislative proposals is less important at this point in the national debate, the Panel believes, than providing policy makers and the public with an overview of the major approaches to reform, and their potential consequences. The Panel's goals in this chapter are to explicate the broad social and political issues involved in reforming this national social insurance program, and to identify the potential benefits and harms that could result.

FROM ASSUMPTIONS TO CRITERIA

The broad social insurance principles discussed in Chapter 2, although critically important, do not provide all that is needed to craft, or to evaluate, specific policy changes. American society, medical technology, and the organization and economics of health care delivery have changed in important ways since Medicare was established. From a projection of costs alone, Medicare has to be changed if it is to provide health security to program beneficiaries in the future. What needs to be made clear at this point is that decisions about Medicare's role in the American health care system in the future and the implications of expanding, maintaining, or diminishing Medicare's role in the larger health care system need to be assessed carefully, and explained clearly to the public, before those changes are put in place.

Evaluating public policy reform options involves applying personal values and ascribed social values to proposals that may not be fully defined, and which may have far-ranging consequences that may be impossible to predict. Fortunately, the Panel had a variety of sources to draw on in devising an approach for evaluating Medicare reforms. Most obviously, the Study Panel was able to call on the expertise of its own members. The Panel was assembled as a group of individuals who have spent their careers (or are embarking on careers) examining public policy and health care reform issues, from perspectives including history and the sociology of science, health services research, philosophy, economics, political science, medicine, and public administration.[1] The review of public opinion research presented in Chapter 3, together with the findings of the Academy's own poll about the future of Medicare and the focus group research allowed the Panel to explore what people experience and what they think about Medicare in some depth. Papers com-

1 Developing explicit value-based criteria to evaluate Medicare reform options derived in part from the work of Daniels, N., Light, D., and Caplan, R., *Benchmarks for Fairness for Health Care Reform* (New York: Oxford University Press, 1996).

missioned by the Panel filled in gaps in the available literature identified by the Panel and staff. With some initial misgivings, but with increased certainty of the importance of the task, the Panel developed a set of criteria — financial security, equity, efficiency, affordability, accountability, political sustainability, and individual liberty — designed to focus on those aspects of values and public policy concerns that policy makers and the public need to consider in the debates about Medicare's future. The Panel offers these criteria for public and individual use in evaluating reform proposals.

Financial Security: *The degree to which Medicare (under the current program or as a reformed program) provides financial security to the elderly and disabled (and their families across generations) as they incur costs for medical care.*

Financial security is fundamental in Medicare's goals as social insurance and health insurance; a key objective is to provide financial security when illness and its costs strike. This insurance protects not only the financial and emotional well-being of the elderly and disabled but also that of their families and others in their communities who care for them. The sense of financial security is valuable not only when someone becomes sick, but at other times as well, because it simplifies the process of devising alternative plans (which might be difficult or impossible to achieve) to insure ourselves and our families in case of illness. For this security to be real, Medicare must be viable not just in the immediate future but for the entire foreseeable future. To lack a plan for financing Medicare at any point into the foreseeable future is to provide less security to future generations than the security received by elderly and their families today.

Equity: *The degree to which Medicare is able to serve all populations fairly, including beneficiaries and future beneficiaries, regardless of age, health, gender, race, income, place of residence or personal preferences.*

Changes to Medicare may have differing effects on individuals and of different ages, generations, gender, race, income, place of residence, and preferences, and people with different types of health care needs. There may be winners and losers no matter what we do, but understanding who they will be and thinking about whether these distributional consequences require addressing is essential. Political pressures aside, we are unlikely to be happy with a reform that places undue burdens on a few, even if it benefits many. How are we to group individuals when considering equity concerns — persons with chronic illnesses, the very old, people unable to afford supplemental insurance, people eligible for assistance from other government programs — or some other set of divisions? Confronting these questions is essential if change is to be successful and sustained.

Efficiency: *The ability of Medicare to promote the use of appropriate and effective medical care for the beneficiary population, i.e. care that is technically efficient and minimizes the use of ineffective or unnecessary services, is consistent with the preferences of patients, and recognizes the real costs of services. Efficiency also includes the degree to which administration of the program is timely and responsive to the needs of consumers and providers, and the application of*

financing methods that are not unnecessarily burdensome.

Getting the most benefit out of the money we spend means promoting the health care of beneficiaries, and is a prerequisite for responsible use of public funds. It makes no sense to stint on benefits or reimbursement if the result is mismanaged or poor quality health care that ends up costing more, whether to the Medicare program, other public programs, private payers, or families, in the long run. Efficiency in the use of health services encompasses the notion of promoting the health and well-being of current and future beneficiaries, and therefore may depend on the program's ability to ensure standards for coverage, benefits, and program performance. Administrative and managerial factors also affect the efficiency of the services provided to beneficiaries, including the ability and willingness of providers to participate in the program and to coordinate the care of patients.

Affordability over time: *The degree to which the costs of Medicare can be borne without diverting public revenues needed for other important public priorities.*

Over time, we may decide as a nation that health care should comprise a far larger proportion of national spending than it does today, or perhaps far less. But as much as we value health, and as much as all other aspects of life depend on it, health is not all we value. No matter how beneficial, a Medicare system that is so expensive that there is no money for us to meet other individual or social goals — both public and private— is not likely to be what we want. Devising ways to determine what we as a nation believe is adequate and appropriate health care (paid for by Medicare or by other payers), and how we are to balance health care with other priorities will be particularly challenging because of the high value we place on health care and on the right to obtain health care, particularly for the elderly and disabled, that Americans strongly support. The system needs to be designed to address, in a politically acceptable way that will have to be revisited over time, questions about both the intensity of service use and the price of health care.

Political accountability: *The degree to which the information needed to determine whether the program is achieving its goals is available, and mechanisms are in place to identify problems and institute corrective actions in a timely manner that is fair to all beneficiaries, to providers, and to taxpayers.*

Medicare will only do what we want it to if we are able to observe what it is doing and force it to change if it is not meeting our goals. This means a system where someone is on watch. Oversight can be performed by government, individuals, their families, providers, or private organizations paid to take on this task. All have strengths and weaknesses in meeting this responsibility; political accountability will require appreciation of the contributions that can be made by all these parties. The appropriate role of government in the Medicare program of the future is politically charged, but the sheer size of the program and the vulnerability of many of the program's beneficiaries makes accountability a pivotal issue in the evaluation of any reform option.

Political sustainability: *The degree to which the Medicare program enjoys the support of the American population, regardless of the state of the economy, political climate, or social atmosphere.*

If we design a system that we like, we want it to last. That means a system that has the ability to be supported over time, in rich times and in poor times, bull and bear markets, through liberal and conservative eras, through baby booms and baby busts. Social insurance must be essentially conservative.

> **Maximizing individual liberty:** *The extent to which Medicare policies, including incentives structured to promote efficiency, allow individual beneficiaries to exercise their own judgment and individual preferences in making choices about their health care*

As much as we may strive to design an ideal policy, and as much as insurance is a collective action, it is essential that Medicare respect our differences as individuals and the inherent value of meaningful choice. This does not mean that there should not be incentives and consequences related to choices; these are basic realities of the presence of scarcity of resources compared to wants in the world. But what it does mean is that, wherever possible, individuals must be able to exercise their own judgement and individual preferences in the context of those resource constraints. Choice is a powerful mechanism for matching resources to needs and wants.

EVALUATING MEDICARE POLICY OPTIONS

The criteria by which public policy can be evaluated can overlap or contradict one another. The Panel's goal is not to prescribe how such tradeoffs among these criteria should be made. In a democratic society, those are decisions that are made through the political process. But in weighing such decisions, we believe it is useful to be systematic in identifying the values at stake so that they may be considered and discussed and the tradeoffs inherent in the policy options that are proposed may be clearly understood.

For the purposes of exposition, we have divided alternative approaches for change into three categories that correspond generally to options that are being actively discussed by policy makers:

- "Finetuning Medicare": Policy changes that are designed to preserve the basic structure of the Medicare program could focus both on sustaining the system's financing, and on addressing problems of equity related to the aging of the population and increases in health care costs. Some of these options would focus on controlling costs and / or increasing taxpayer or beneficiary costs. Others would "modernize" Medicare, by reforming its administration and management, particularly its fee-for-service program, or expand the Medicare benefits package to reflect beneficiary needs and market demand, or broaden eligibility, e.g. expanded opportunities for buy-in for individuals who cannot obtain health insurance in the marketplace.
- "Restructuring Medicare": This approach would transform Medicare into some version of "managed competition," drawing on models used in public and private employee health insurance programs. In general, this approach would have Medicare manage a system in which a variety of managed care and fee-for-service health plans compete for enrollees on the basis of price and quality of care, and Medicare provides a "defined contribution" toward the cost of beneficiaries' health insurance premiums, and beneficiaries selecting higher-cost plans pay more.

- "Individualizing Medical Insurance": This approach would replace Medicare with some system of individual savings to pay for health insurance after retirement ("pre-funding"). The system would still require mandatory contributions, but would not necessarily involve any inter-generational pooling of risk or redistribution of resources.

In this section, we briefly describe the major features of Medicare reform alternatives, and then evaluate them in the light of the criteria discussed above. This evaluation focuses on the likely directions of changes for the Medicare program and for the people it serves, in terms of affordability, equity, efficiency, and the broader political and social implications of these options.

The Current Program

In order to work through the implications of policy changes, it is essential to review how well the *current* program conforms to the criteria that have been set out for evaluating Medicare policy options. Today's Medicare program, the single largest health insurance program in America, has applied the principles of social insurance — including universal coverage for the elderly and disabled populations, objective standards of qualification, and no application of means testing — to help tens of millions of people and their families avoid unexpected medical costs and possible financial ruin. To an extent unanticipated in 1965, Medicare has created a sense of security and belonging (equity), and an acceptance of mutual obligation between working and retired people that we believe is politically and socially important to the fabric of American society. Medicare is one thing that most Americans, across generations, and across socio-demographic lines value highly (see Chapter 3).

The most obvious failings of Medicare as it is currently structured are its affordability over time and its continuing focus on hospital-based services. As discussed in Chapter 1, the rate of increase in spending has consistently exceeded that of the domestic economy as a whole. The "right" amount of spending for health in an aging society in which the economy is expanding is yet to be agreed upon, but under current law, the Hospital Insurance (HI) Trust Fund is projected to become insolvent in about a decade.

Despite its substantial contribution to the health and economic security of elderly and disabled Americans, Medicare has been only partially successful in meeting its basic goal of providing for the financial security of the elderly and disabled and their families across generations. Personal (out-of-pocket) costs for health care services — now 19 percent of average beneficiary income (see Chapter 1) — are a significant problem for many beneficiaries. Medicare's benefit package has not kept pace with changes in the way health care is provided, particularly with respect to coverage of prescription drugs, and is inadequate for the needs of many with chronic or long-term care health and personal care needs. Further, as the costs and intensity of health care services used by beneficiaries have increased, Medicare cost-sharing among the beneficiary population has risen substantially, and is projected to increase far more under current policy. Estimates generated by the Urban Institute (using the Medicare Trustees' baseline cost assumptions) are that by the year 2010, beneficiary premiums and coinsurance alone could rise to about 15 percent of the median beneficiary income. The model predicts that beneficiary liability could increase to almost 18 percent of median income by the year 2025 (Moon, July 21,

1998). This liability is in addition to out-of-pocket expenses for non-covered medical expenses (including eyeglasses, hearing aids, or dental services, as well as prescription drugs) and expenses for Medigap insurance. An insurance program that leaves beneficiaries with costs that may exceed one third of their annual income would fail to meet its most basic objective of providing financial security for families across generations, and could lose much of its political support.

Medicare has helped to transform American health care, and has done so on a firm foundation of egalitarian principles. It provides a standard benefit for all beneficiaries, and requires compliance with national standards for nondiscrimination, access to care, consumer protection, and quality of care. Disparities in access to care and health care outcomes still exist across economic, racial and ethnic, and geographic subgroups in the beneficiary population. These differences, however, do not necessarily reflect flaws in what Medicare does as an insurance program. People enter the program with medical histories that have shaped their access to and use of health care in a variegated system of commercial, employer-sponsored, public, or philanthropic health insurance and health care services. For people who have worked in low-wage jobs and/or for small employers, Medicare is often the first stable health insurance they have ever had. Variations in access to and comprehensiveness of supplementary insurance (which has been shown to affect the use of health care services) tempers the goal of equivalent access for beneficiaries (see Chapter 1).

Whether the government can run Medicare efficiently is at the core of much of the political debate about the program. On objective criteria, it is not hard to make the case that Medicare is a well-run program. The current method of collecting revenues via payroll taxes is commonplace in social insurance, both because of its administrative efficiency and because it clearly links work to retirement benefits. The administrative expenses for Medicare (less than 2 percent of claims) are far below those of private insurance programs and HMOs (estimated to be about 10-12 percent; U.S. DHHS, HCFA, 1996). HCFA has taken on tremendous responsibilities in the regulation of nursing homes, home health agencies, and other health care facilities as well as management of Medicare, and Medicaid. It has supported the research and development work that led to major reform of both hospital and physician payment, and, because of these innovations, held expenditure growth per beneficiary over much of the past 25 years to a rate of growth that is lower than the per capita cost rate increase in the private insurance system (Levit, et al., 1995). Research and development supported by HCFA has been widely used by other public and private payers. At the same time, critics cite the agency's inability to deal effectively with billing and provider fraud, major problems with HCFA automated data systems, its inability to meet statutory deadlines, and a host of other problems (see, for example, U.S. Congress, GAO, January 29, 1998).

In part, efficiency problems are a function of the complexity of the program. Whether Medicare's administered pricing systems are inherently less efficient than systems based on market competition is the subject of considerable debate, and Medicare's record of controlling health care expenditures is no worse (and in some regards better) than the private sector's. There are, however, obvious exam-

ples of inefficiency in the pricing of some Medicare services, such as durable medical equipment and oxygen.[2] There is also considerable agreement that centralized pricing and administration can be rigid and unresponsive to local circumstances (U.S. Congress, CBO, May 1998). The arcane rules and regulations undoubtedly contribute to mistakes, procedural errors that result from inadequate billing and claims processing staff training, systematic abuse, and serious fraud that plague the program.

Medicare's accountability to the public and to policy makers is often criticized. Nevertheless, Medicare is a federally-administered program, and it is directly accountable to the public and to Congress in very specific ways. There is an established system of administrative review and judicial appeal available to beneficiaries and providers. Medicare's operations and budget are closely scrutinized by the Department of Health and Human Service's Office of the Inspector General, and by the Congress and its oversight agency, the General Accounting Office (GAO). In the first nine months of Fiscal Year 1998 alone, GAO had completed 35 reports or written testimonies presented at Congressional hearings on various Medicare oversight issues.

The last criterion by which options for restructuring Medicare should be compared to the current program, maximizing individual liberty, is among the most controversial in the current health care debate. Medicare, an insurance program which is still predominantly a fee-for-service payer, allows current beneficiaries more freedom of choice of health care providers and physicians than most employer-sponsored health insurance plans. Unlike Medicaid, Medicare operates under strict statutory rules ensuring freedom of choice among providers and among health plan options. Medicare beneficiaries do not have to enroll in managed care.[3] As is discussed below, approaches to restructuring Medicare that have been proposed to help control costs may introduce more options for obtaining health insurance, but may also entail financial incentives that directly or indirectly limit the choices of providers or practitioners that beneficiaries may have in the future.

Fine-tuning Medicare

Many of the policy options that have been proposed attempt to address Medicare's most pressing problems, i.e. the impending depletion of the Medicare HI Trust Fund, and, more generally, the costs that will be incurred

2 In 1997, for example, HCFA asked Congress for legislation that would allow it to reduce its payment for home oxygen equipment. Using the formula prescribed in law, HCFA was paying about $325 for the same equipment that the Department of Veterans Affairs was able to get for $126 through a competitive bidding system (U.S. DHHS, HCFA, July 11, 1997). Similarly, the Inspector General for the Department of Health and Human Services found that charges for Medicare enteral nutrients are as much as 42 percent above market prices, and the General Accounting Office found that the fee schedule prices Medicare is required to pay for intermittent urinary catheters is almost twice the average market price ($1.43 to $1.68, compared to $.87; U.S. DHHS, HCFA, May 29, 1998).

3 Medicare beneficiaries who are enrolled in managed care plans have somewhat greater freedom to move from one Medicare plan to another than do most people insured through employers; when the open enrollment and lock-in arrangements for Medicare+Choice plans are fully implemented (after 2002), beneficiaries will be "locked in" (with certain exceptions) to a plan (which can either limit their choice of doctors or hospitals, or provide financial incentives to choose from among a select group) until the next annual open enrollment season.

in providing benefits to the Baby Boom generation when its members become Medicare beneficiaries. For the purposes here, proposals can be further categorized into two distinct sets. One set includes proposals to keep the program within acceptable fiscal bounds, either by limiting payments to providers or suppliers, reducing eligibility, or increasing beneficiary cost-sharing. The second set would expand participation or benefits in order to make Medicare a better insurance program, but without making major changes in the structure or general financing of the program. The individual reforms subsumed within these sets are not mutually exclusive, and, in fact, a reform package would likely include some elements of both.

Revenues and Cost Containment

The most commonly mentioned approaches to controlling Medicare spending[4] have been discussed in the media, and addressed in public opinion polls (see Chapter 3). These include:

- reducing payments to providers through various technical changes in payment methodologies
- increasing the Medicare payroll contribution rate
- increasing beneficiary cost-sharing (premiums, copayments or deductibles)
- increasing cost-sharing for "high-income" beneficiaries
- increasing the age at which beneficiaries receive Medicare benefits (in coordination with increases in the age of eligibility for Social Security).

Rather than evaluating each policy option in detail, we focus on those aspects of the policy options that might lead to the most significant changes in Medicare in terms of the evaluation criteria discussed earlier. All of the policies are designed either to slow the rate of increase in program expenditures or to increase revenues to stabilize the program over time. They differ with respect to how they distribute any additional cost burden across the working and beneficiary populations (equity), their likely effects on administration of the program (efficiency), and their possible effects on beneficiaries' ability to choose among providers (individual liberty).

Policies designed to reduce payments to providers have been the primary means for controlling costs in the Medicare program for the past two decades. Medicare payments for physician and hospital services are lower than those paid in the private sector[5] (U.S. Congress, CBO, May 1998). Analysts have expressed concern that while Medicare beneficiaries do not currently seem to experience difficulties gaining access to health care, continuing to ratchet down reimbursement rates could lead providers to withdraw from participating in the Medicare market (as many did from the Medicaid market). Low payment rates could lead to special problems for bene-

4 Reducing or eliminating support for other programs currently paid for with Medicare funds, such as support for graduate medical education has also been discussed as a means to reduce Medicare spending. This differs from other options for cost savings in that it does not directly affect the Medicare benefits package or beneficiary costs. These programs represent a fairly small proportion of total program expenditures (see Chapter 1). As discussed in Chapter 2, decisions about the appropriateness and desirability of these programs need to be addressed on their own merits.

5 CBO reported in 1998 that current estimates are that Medicare pays only 70 percent to 80 percent of the average rate that private insurers pay to hospitals and doctors (U.S. Congress, CBO, May 1998).

ficiaries without adequate supplemental insurance, and for low income beneficiaries who are not able to get to providers who are willing to accept low rates. Beneficiaries might be less able to find, or to afford to see, doctors who can deal with their serious or complex health problems effectively.

Increasing Medicare revenues is politically charged. As the discussion in Chapter 3 indicates, public opinion polls have generally shown support for some increases in taxes if the alternative is cutting Medicare benefits. Despite the increase in the costs of medical care, the Medicare payroll tax (1.45 percent paid by both employers and employees) has not been increased since 1986.[6] The notion of tax increases of any kind has been generally unpopular since the Reagan Administration. There may also be some perception (see Chapter 3) that increasing payroll taxes is not equitable unless the benefits of the increase — a stable Medicare program with adequate benefits — can also be guaranteed to later generations. There is some evidence that Americans have become more skeptical about whether the program will be available and adequate to their needs when they need it. And while Medicare payroll taxes are levied on an uncapped income base, and also levied on income derived upon the exercise of stock options (so that higher income individuals contribute considerably more to the HI fund), the flat rate tax may place a more serious burden on low-wage employees.

It is also important in this regard that payroll taxes account only for part of Medicare revenues (88 percent of Hospital Insurance Trust Fund revenues, which accounted for 66 percent of total program expenditures in 1997). General revenues account for 75 percent of the Supplementary Medical Insurance (part B) revenues. As Part B expenditures and beneficiary cost-sharing increase, the portion of the program financed by payroll taxes decreases. There was some suggestion, in the focus groups conducted by the Academy, that some form of revenue that could be assessed progressively, across the board, but specifically earmarked only for Medicare, might be considered more favorably than a payroll tax increase. This would provide another means (in addition to the Social Security benefits tax allocated to the HI Trust Fund; see Chapter 1) of having higher-income beneficiaries (including those whose incomes come from investments or other non-wage earnings)[7] contribute more to the program, without increasing the burden on lower income workers or beneficiaries. Clearly any system calibrating contributions in this way would have to be assessed in terms of the costs and efficiency of making such contributions relative to the likely revenues gained.

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6 The HCFA Office of the Actuary has estimated that a .25 percent increase in the tax rate for employers and employees (each) would extend the date by which the HI Trust Fund would be exhausted to 2020; a one percent increase (resulting in a combined total of 4.9 percent split between employers and employees) would allow the Trust Fund to remain nearly solvent over the next seventy-five years (Foster, Mussey, and Weinstein, 1998).

7 In 1998, CBO estimated that 51 percent of families headed by someone aged 65 or more (46 percent of elderly individuals) had incomes that result in having zero tax liability. In other words, about half of elderly beneficiaries over 65 pay some income taxes (part of which currently helps to finance Medicare). (U.S. Congress, Green Book, May 1998).

Increasing beneficiary cost-sharing across-the-board raises questions of financial security and equity. Most beneficiaries have modest or low incomes (see Chapter 1). For those on Medicaid, the increased costs would probably be passed to this other federal program, so that the poorest beneficiaries would be largely shielded from new costs, but the government would still be paying the bill. For those with limited or no supplemental insurance, increases in cost-sharing could be very harmful. Premium costs for those with private or employer-sponsored supplemental policies would likely increase. Some analysts, based on past history of the employer-based supplemental insurance market, believe that many would nevertheless retain comprehensive ("first dollar") coverage because it is a benefit that is highly valued by employees (and carries with it tax advantages for both employers and employees). Comprehensive first-dollar coverage is associated with higher rates of use of services, which some analysts believe could cancel out most of the revenue gains from the policy change (U.S. Congress, CBO, May 1998).[8]

Another dimension of cost-sharing involves administrative as well as financing issues. The complete separation of Medicare Parts A and B,[9] with different cost-sharing requirements for individual services within the two insurances, makes Medicare copayments and deductibles extremely complicated and burdensome. Some proposals would create a single Medicare deductible (for Parts A and B).[10] In addition to making the system simpler, this would allow policy makers to develop a more rational approach to establishing overall cost-sharing levels. This could provide a means of structuring a predictable and manageable "front end" liability, while reducing or eliminating catastrophic "back end" liability for those incurring huge hospital and medical expenses. A single deductible could be indexed (e.g. to some measure of health care cost inflation), which could provide greater financial protection to beneficiaries. It could also provide Congress with a means of adjusting Medicare revenues to pay for program enhancements (which could lead to higher overall levels of beneficiary cost-sharing).

Increasing cost-sharing for higher-income beneficiaries introduces difficult issues from the perspective of the Panel's criteria. The potential (relatively small) increase in revenues, given the economic resources of the beneficiary population, needs to be weighed against the social and political costs of making such a move. From the perspective of equity, some argue that increasing cost-sharing for higher-income beneficiaries is fair, and is consistent with principles of sharing risk and redistribution of resources embodied in the principles of social insurance (see Chapter 2). Higher-income beneficiaries are already

8 CBO estimates that Medigap coverage increases enrollees' use of services by an estimated 24 percent (May 1998).

9 Proposals to actually merge Parts A and B of Medicare would allow Congress to shift revenue between the parts; greater use of Part B funds (largely from general revenues) could prolong the life of the Part A (HI) Trust fund. Implications of merging the trust funds are being discussed by the Academy's Study Panel on Medicare Financing.

10 In a paper commissioned by the Academy's Study Panel on Medicare Financing, Thomas Rice points out that "In considering the current [1998] deductibles of $764 and $100 for Parts A and B respectively, it is noteworthy that originally the Part B deductible was actually higher than for Part A ($60 vs. $50)" (Rice, 1998).

contributing extra revenues to the Hospital Insurance Trust Fund via the Social Security benefits tax provisions. Proponents also point out that the policies that have been implemented to assist low-income beneficiaries (through the Medicaid program) with cost-sharing, e.g. the Qualified Medicare Beneficiary (QMB) program (see Chapter 1), already have moved Medicare in the direction of an income-related program[11] (Gage, et al., 1997).

The counter arguments relate both to administrative issues and to concerns about universality and equality. Assessing higher costs to higher-income beneficiaries could be done through income-relating premium payments (which would require Medicare to assess different monthly premium deductions, based on information obtained from the Internal Revenue Service), by reducing reimbursement (in fee-for-service) or assessing higher coinsurance or deductibles, or by levying a "surcharge" to higher-income beneficiaries annually through the income tax system (over and above the current benefits tax provisions). The last of these options, which is administratively far simpler than the alternatives, was used in the short-lived Medicare Catastrophic Coverage Act of 1988, and, even though the increased revenues were specifically targeted to new Medicare benefits, there was some intense negative reaction to the law. Charging more to some beneficiaries at the point of payment would likely be administratively complicated, and possibly stigmatizing to those who earn less than those required to pay the higher cost-sharing payments (differentiating those "who pay their own way" from those who "need to be subsidized by the government"). In addition, people who are high earners during their work lives would know that they were most likely going to have to pay more for Medicare-covered services when they became eligible, perhaps leading them to opt out of Medicare altogether (assuming this is an alternative). Not only would this reduce Medicare payroll tax revenues, but, because higher income beneficiaries are, on the whole, healthier than lower income individuals (see Chapter 1), it could result in biased selection in the remaining Medicare risk pool. From an insurance standpoint, there are strong arguments for keeping the Medicare risk pool as broad as possible.

Increasing the Medicare eligibility age also highlights tradeoffs between equity and meeting the broader social goals of the program. Change in the age of eligibility for Social Security has already been enacted (in 1983), with the transition to age 67 beginning in 2003, and phasing in completely by 2027. Beneficiaries are living significantly longer than they were in 1965, and are, as a whole, in better health. In the Academy's focus groups, some beneficiaries seemed to think it was logical and fair that the age of Medicare eligibility be raised. The problems with the proposal, also raised in the focus groups, revolve around the implications for older people with health care problems that are already evident at earlier ages (including some where early diagnosis may reduce costs later), the effects on people working in physically taxing jobs who may need health care earlier than others, and the availability and affordability of health insurance in the private market for older people. The market for

11 In the QMB and other public Medicare supplement programs, however, the income-related part is operated through Medicaid, but Medicare coverage is identical for all enrollees.

health insurance for people aged 55-64 is increasingly inaccessible to people with health care problems and people with limited incomes (see Chapter 1). Increasing the age of eligibility to 67 could leave a substantial number of people, many no longer in the workforce, without health insurance.[12] Because at least some of the most seriously ill people become unable to work and qualify for Medicare before reaching the normal age of eligibility, Medicare will incur some of the higher health care costs associated with seriously ill or disabled people in any case. Expenditures for most beneficiaries in their 60s and early 70s are relatively low, compared to older beneficiaries (Chapter 1). Therefore the savings from foregone payments for persons aged 65 and 66 will be small in comparison to the projected need for revenues. The costs to individuals, their families, and other public programs such as Medicaid need to be weighed against the potential savings Medicare might achieve.[13]

Modernizing Medicare

A second set of fine-tuning options are designed to address operational and administrative issues, and, incrementally, to work within the existing program to address some more fundamental health policy issues, such as problems in access to health insurance for older working individuals, and the inadequacy of the Medicare benefits package. These proposals do not address the Medicare financing problem directly; they are, in fact, likely to be linked with other proposals designed to reduce program costs, or, in political jargon, provisions to ensure "budget neutrality." The goal is to help the Medicare program achieve the goal of providing the security it was intended to provide without making major structural or operational changes to the program. A secondary goal, however, could be to create a stronger, more stable Medicare program that could be viewed more legitimately as a foundation for broader reforms targeted to providing health insurance to otherwise uninsured populations.

Administrative reforms, such as those advocated by the Academy's Study Panel on Fee-For- Service Medicare, focus on increasing program efficiency by giving the Health Care Financing Administration (HCFA) more flexibility and autonomy (along with accountability) to innovate and implement program changes designed to improve the efficiency and effectiveness of beneficiaries' health care. If it were more fully empowered to do so by Congress, HCFA could, for example, move more quickly to adopt and expand upon proven health care management practices of private health plans; e.g., experiment with disease and case management; provide beneficiaries with incentives to use selected providers; and develop specialized approaches for competitive procurement in fee-for-

12 One estimate is that about 500,000 persons aged 65 and 66 would be left without health insurance if the eligibility age were raised to 67, and many of those able to purchase some form of policy would be able to afford coverage less complete than that offered by Medicare (Waidmann, 1998).

13 In a paper commissioned for the Study Panel, Cassel and Siegel (1998) argue that the automatic link between Social Security and Medicare eligibility should be reassessed. While many older people are fully able to remain in the workforce longer than they could a generation ago, obtaining adequate health insurance is increasingly difficult for older workers. Making affordable Medicare coverage available to older workers could help them to remain in the workforce longer, where they could continue to contribute to Social Security and Medicare through payroll taxes.

service Medicare. In some instances, greater flexibility might include providing expanded benefits, such as case management services, or specific in-home drug therapies, if these would result in more efficient use of services and improved patient outcomes. In other instances, competitive procurement could lead to more limited choice for beneficiaries, who might be given financial incentives to select from among only those providers qualified to offer specialized services at competitive rates (NASI, January 1998).

Administrative reforms of this sort would require not only additional statutory authority, but a reorientation in HCFA's approach to managing the program, away from operating primarily as a bill payer, toward assuming broader responsibility for Medicare beneficiaries' overall health. One major issue relates to Medicare's importance in many health care markets. The fee-for-service program has been open to all qualified providers; reforms that would limit the number or type of participating providers (in order to secure services from the most efficient in particular markets) could result in substantial, or even fatal losses to some provider organizations. This could clearly generate major political problems in specific areas. Further, to become an organization that actively managed health care, HCFA would need resources and staff with fairly specialized skills. It is not at all clear whether these resources would be made available, or whether a large executive branch agency would be given the autonomy to carry out an aggressive program of innovation and experimentation in an environment in which government is viewed negatively (Brown, 1998). Further, if experiments do not work out well, as is often the case in many other areas of the economy, it is not only the consumers and stockholders of the health care companies providing services who may pay the price, but the government and its taxpayers.

Redesigning the Medicare benefits package is pivotal in the discussion of program retooling as well as program restructuring. Not only do the gaps in the current Medicare benefits package result in exposure to health care costs that seriously threaten the economic security of some beneficiaries and their families, but also lead to the demand for secondary insurance that limits the effectiveness of efforts to control program costs (NASI, April 1998; Rice, 1998). As discussed above, supplemental policies insulate most beneficiaries from the actual costs of Medicare services; in effect, the gaps in the Medicare benefits package have spawned an inefficient secondary insurance market.

Expanding the Medicare benefits package would most likely increase total program costs, and therefore put additional strain on the Medicare budget.[14] It is possible, however, that a broader benefit might facilitate better coordination and more efficient use of chronic care and long-term care services, and reduce some of the inefficiencies associated with the current system of supplementary insurance. Looking only at Medicare costs rather than the total costs for beneficiaries limits the utility of the debate. The Study Panel believes that a careful analysis of the

14 As noted in Chapter 1, many Medicare health maintenance organizations are able to cover the costs of providing additional benefits, including prescription drug coverage and preventive care services with the capitation payments they are currently receiving from Medicare.

costs and benefits of redesigning the Medicare benefit package needs to be part of the discussion about Medicare's future. The current package no longer reflects the way that medicine is practiced; the access to care and protection from financial ruin promised by Medicare is being eroded by the costs of prescription drugs and potentially catastrophic levels of cost sharing. For a growing number of elderly and their families, the costs of dealing with chronic illness and impairment, including community-based as well as institutional long-term care, are ruinous. Figuring out how these costs can be allocated fairly and efficiently among public payers, private insurers, and individuals and their families makes the task of reforming Medicare far more difficult that it would be if the only issue were controlling program costs, but it could, in the Panel's view, have far more beneficial results.[15]

Allowing buy-in to Medicare for people younger than 65 introduces issues that extend beyond "fine-tuning."[16] In terms of financial security, expanding the program to people who could not otherwise find comprehensive health insurance in the marketplace has clear value. There are, however, a number of issues related to equity; in particular, determining who is eligible for the program, and who would be required to remain in whatever employer-sponsored plan might be available to them, even if the coverage was less complete than Medicare, could be problematic. There are also questions about whether significant numbers of people would be able to afford to buy Medicare insurance (at about $350 per month).

Structuring Competitive Medicare Markets

The reforms introduced by the Balanced Budget Act of 1997 (P.L. 105-33) were designed to expand consumer choice and provide more opportunities for providers and insurers, creating, in effect, a "Medicare marketplace." These reforms did not, however, directly affect the financing or organization of the indemnity insurance model that governs fee-for-service Medicare. Even under the most "aggressive" assumptions, the majority of Medicare beneficiaries are expected to remain in fee-for-service Medicare for the next two decades. Integrating Medicare fee-for-service into a system where market forces can be relied upon to rein in program costs would entail significant restructuring.

A range of proposals under consideration in policy circles are based on models that would replace Medicare's current system, in which Medicare agrees to reimburse providers for the costs incurred in covering a defined benefit, with a system in which Medicare would pay for a defined portion of the cost of enrollees' health insurance. The key difference is that, instead of Medicare paying a set price for all participating providers in an area, the price of the health plan premium for each enrollee would be determined through some form of market competition, and beneficiaries would choose among plan options based on the cost and attractiveness of the product (perceived quality, convenience, etc.). In the current Medicare system, beneficiaries pay

15 The Academy's Study Panel on Medicare Financing is examining alternative approaches to designing and paying for a range of expanded benefits.

16 The Academy's Study Panel on Medicare Financing is also examining issues surrounding a lower Medicare eligibility age option.

the same monthly premium, and qualified plans contracting with Medicare receive the same payment for each enrollee regardless of the plan's real costs, efficiency, or the richness or quality of the services it provides. In a structured competition system, each health plan would establish its price, and apply to participate in the Medicare market through some form of market-specific pricing system. Medicare would pay some fixed amount or a fixed proportion of the cost of insurance in each market area, but that payment would not cover the full cost of all the plans — Medicare might, for example, peg its payment rate to the median of the premiums for qualified plans in an area. Beneficiaries choosing plans that cost above the median would have to pay the extra costs of higher cost plans, and those choosing the lowest cost plans would pay less.

One version of managed competition models proposed for Medicare is based on a "premium support model" in which Medicare could pay a defined proportion of the cost of an insurance policy or health plan premium (Aaron and Reischauer, 1995). Premium support models, in the discussion in this report, include elements of both a defined benefit and defined contribution approach. The federal payment would be pegged to a specified percentage of the cost of health plans providing a statutorally-defined Medicare benefit package. For example, Medicare could choose to pay 88 percent of the average cost of all plans in an area agreeing to provide the full Medicare benefits package (disregarding the cost of services that the plan might want to provide over and above the basic package). This model differs significantly from voucher models (described below) in which Medicare would provide a specific dollar contribution that individuals could use toward the payment of premiums for a wide range of insurance products with different benefit designs.

In its final report *Structuring Medicare Choices,* the Academy's Study Panel on Capitation and Choice developed the framework for a premium support model for Medicare that can serve as the point of discussion. In that model, Medicare benefits would be expanded to more closely approximate the coverage that beneficiaries seek through supplemental insurance now, i.e., some, if not complete coverage of prescription drugs, catastrophic coverage for total Part A and Part B and somewhat lower Part B copayments. This would in theory supplant a significant portion of supplemental insurance.[17] Total payments to plans would be established through competitive bidding. Medicare would determine a fixed dollar contribution toward the cost of premiums for all participating plans. Medicare's actual payments to plans would then be adjusted using an appropriate risk adjustment method (to take into account each individual's expected use of services), assuming an appropriate risk-

17 The Panel report presents the argument that the additional costs would be less than the cost of purchasing that coverage in the private market. It is also possible that a better-designed benefits package could reduce incentives for beneficiaries to seek out supplemental coverage, then select first-dollar coverage options, which are believed to contribute to higher utilization rates. Medicare fee-for-service coverage that looks more like insurance available in the employment-based market might actually "level the playing field" among plan options, encouraging beneficiaries to compare costs and benefits of managed care and fee-for-service plans directly, without having to factor in additional supplemental coverage. At the same time, the report recognizes that an expanded benefits package could trigger significant changes in employment-based supplemental coverage, and in state and federal responsibilities for beneficiaries eligible for Medicaid.

adjustment methodology is available. Medicare payments to plans would therefore vary by the health risk category of each enrolled beneficiary as well as other predictors of use such as age. For example, Medicare would pay more per month for beneficiaries who had received treatment for breast cancer, or insulin-dependent diabetes, than for healthier beneficiaries. The premiums paid by individual beneficiaries within each plan, however, would not vary with an individual's health status. Beneficiary costs (in the form of increased premiums and copayments) or savings (in the form of reduced premiums and added benefits) would be determined based on the difference between a plan's bid premium price and the Medicare contribution. All beneficiaries would be guaranteed all Medicare-covered benefits, but beneficiaries would pay more out-of-pocket for plans that were more expensive due to differences in practice style or efficiency, or for plans that offered extra benefits. Beneficiaries would not pay more because they are at greater risk of needing health care, or because they enrolled in a plan with sicker than average enrollees.

A second (voucher) approach to structuring competition in the Medicare market differs in a fundamental way from the premium support model. Rather than continuing to guarantee a defined benefit to be provided by any health plan enrolling Medicare beneficiaries, Medicare could simply provide a defined "cash" amount toward the cost of health coverage (see, for example, Butler and Moffit, 1995). Supposing, for example, as discussed by CBO (May 1998), Medicare pegged its contribution to the estimated average cost of Medicare coverage per enrollee (adjusted for geographical differences in costs) in the year 2000. Medicare's contribution would them be increased by the average annual rate of projected growth in per capita GDP, calculated to be 4 percent. Beneficiaries would be given "vouchers" for this amount (risk adjusted as discussed above). Beneficiaries would be free to apply the voucher amount to the premium for the plan in which they chose to enroll.

The differences between the two defined contribution models are very important. In the premium support model, there is a standard Medicare benefits package defined in law, and Medicare guarantees to pay a fixed proportion of the market cost[18] of these defined benefits provided by some set of qualified plans in each market area. Because the benefits would be defined in statute, there would be some assurance that Medicare would continue to pay for a fixed proportion (likely in the 85-90 percent range)[19] of the costs of appropriate and necessary health services. If the costs of premiums increase substantially over time (and increase faster than inflation or beneficiaries' incomes), beneficiaries' costs would increase in absolute terms, and more beneficiaries might need to restrict their plan choice to lower-cost plans. Premium support models therefore offer a limited guarantee of the financial security beneficiaries and their families value. It could

18 The contribution rate could be pegged to the median bid price, or set at some other level based on a formula that is designed to produce an efficient payment level that will guarantee that beneficiaries can make meaningful choices among alternatives (NASI, April 1998).

19 The Federal Employees Health Benefits Program pays 72 percent of a weighted average premium cost computed from plan premiums and number of subscribers, but no more than 75 percent of the lowest priced plan (NASI, April 1998).

also be argued, however, that market competition could hold down prices, at least in some markets, allowing beneficiaries to get "a better deal." There is, in fact, no way to know whether premium support models would result in cost savings either to beneficiaries or to the Medicare program. The model is based on the belief, grounded in the experience of some existing systems of structured choice, that competition based on price and quality will result in more efficient delivery of health care.[20] This stands in contrast to defined contribution models using the voucher approach, without a defined benefit. Vouchers can guarantee the reduction in the rate of spending in Medicare, but cannot guarantee that Medicare will continue to pay most of the cost of a comprehensive benefits package over time, at prices beneficiaries can afford. Maintaining the comprehensiveness of the coverage offered to beneficiaries would depend on explicit political decisions about whether to maintain budgets or preserve benefits.

Both premium support and voucher models could lead to problems of equity if special provisions are not made for low-income persons, or those living in areas where competition is limited by population size or geography. In the premium support model described by the Academy's Study Panel on Capitation and Choice, the current policies for assisting low-income Medicare beneficiaries through the Medicaid program would be maintained and possibly expanded. Supplemental benefit payments would be used, in conjunction with the actual methods used to set the government contribution, to help ensure that all beneficiaries had a meaningful choice among plan options, and low income beneficiaries would not be limited to the lowest cost plan in their area. Maintaining this choice would increase Medicare (and/or Medicaid) costs, and would entail administrative costs as well. Even with these beneficiary protections, access to high-end plans would likely be limited for many beneficiaries. The enhanced benefit package proposed in Capitation and Choice Study Panel model could, however, reduce the need to purchase supplemental insurance, which could be particularly helpful to beneficiaries who do not currently have supplemental insurance, or who pay for Medigap policies on their own. Without these protections, a premium support or a voucher model could place lower income beneficiaries who do not have supplemental insurance or Medicaid at serious risk of being under-insured. (On the other hand, hypothetically, private insurers might devise new forms of supplemental insurance to cover other services, stimulating new demand for care outside of Medicare, and pushing total costs up for beneficiaries).

Although structured competition models are explicitly designed to take advantage of market efficiencies, guaranteeing that the market

20 One piece of evidence supporting the view that structured competition work wells comes from the aborted experiment in competitive pricing for HMO services in Denver, Colorado. The demonstration operated long enough to solicit and obtain bids from health plans. These bids indicated that health plans would offer an enriched benefit package (including prescription drug benefits) to Medicare enrollees, without charging extra premiums, for amounts significantly lower than HCFA's established payment rate for HMOs in the area (Vladeck, 1998). However, because the demonstration was canceled by the Congress in 1997, before enrollment actually began, it is not possible to determine if the plans could actually have provided these services to a cohort of enrollees that reflected the full range of health care needs of the elderly and disabled, over time, for these premiums.

"works" fairly and efficiently for all beneficiaries involves very difficult questions about administration and regulation of those markets. Medicare is currently a national program with national standards. Moving to competitive bidding and administration at the local or regional level makes implementation of national standards more difficult. It also requires the development of a local infrastructure that is not currently in place. The Study Panel on Capitation and Choice advocated a wide range of national standards to be applied to the collection and dissemination of information about competing plans, performance standards relating to marketing, access to care, continuity of care, quality and utilization review, and consumer education and assistance. In addition, the Panel called for expanded support to local entities that could provide beneficiaries with one-on-one assistance in navigating the evolving system of Medicare health plan options. These would help ensure program accountability, but would entail a significant investment in infrastructure. In a voucher model, variation in plan benefits would make implementation of national standards extremely difficult. Individual plans would make decisions about the types of benefits they offered, and the methods they would use to control costs and maintain efficiency in the delivery of services. This could raise serious questions about what constitutes "reasonable" care, and about what recourse would be available to beneficiaries who enroll in plans that fail to provide what individuals believe is appropriate care (Daniels and Sabin, 1998). Individuals would bear more responsibility for the decisions they make. For some, this would mean an increase in individual liberty and in accountability as well, because they might be able to buy the kind of insurance that worked best for them, and to bargain more directly with health plans on issues of cost and quality. For others, navigating the health care marketplace could be quite difficult and dangerous. Adverse selection, where those most in need of health care choose plans that offer the most comprehensive benefits, while those with limited needs opt for low-cost plans, could result in spiraling costs for the sickest beneficiaries.

Individualized Medical Savings

A third approach to solving the Medicare funding problem would replace the current system with one that would be based on "pre-funded" individual medical savings accounts (MSAs). This approach can include provisions consistent with the basic principles of social insurance, including mandatory contributions, earmarked revenues for benefits, and statutory provisions for eligibility and distribution of benefits. There are, however, two areas where individual accounts may differ substantially from the current Medicare program: the extent to which there is pooling of risk, and the extent to which there is redistribution of resources to subsidize the benefits provided to low-wage participants.

The model developed by Thomas R. Saving and Andrew Rettenmaier of the Private Enterprise Research Center, which was presented to the Senate Committee on Finance, Subcommittee on Health in 1997, and described more recently in the *New England Journal of Medicine* (Gramm, Rettenmaier, and Saving, April 30, 1998; Rettenmaier and Saving, December 22, 1998) serves as an example for discussion purposes. In one version of the Saving-Rettenmaier model, each age cohort, defined as individuals born between January 1 and December 31 in any given year, would insure itself against the retirement medical expenses by making a

mandatory contribution to an insurance fund established for that cohort. A second version defines ten-year cohorts. Contributions would be a fixed percentage of earning, but the annual cumulative funds from each cohort would be divided equally and deposited in each person's individual retirement account. In each version, the cohort becomes the risk pool, and as it ages, the required premium would be adjusted as necessary, based on the revealed risk of the group. Special arrangements would be needed, for example, if a cohort encountered some form of catastrophic situation such as war or other disaster that seriously affected its payroll contributions and / or health risks.

Contributions would be treated as individual medical retirement accounts, and insurance would only come into play as an individual reached retirement age and had medical expenditures that exceeded the policy's annual deductible. The model is therefore functionally equivalent to a catastrophic policy that was purchased during a worker's years in the labor force. The policies would pay no survivors benefits should the policy holder die before reaching retirement age. The model proposes that each cohort subsidize the medical account costs of those who cannot pay into the fund, so that all redistribution is within cohorts, rather than across generations.[21]

For workers near retirement when the plan was initiated, contributions would go towards the purchase of a catastrophic insurance policy. The longer the individuals' remaining working years, the lower the deductible. If the worker's contribution covers the price of the catastrophic policy, then additional contributions could be applied toward reducing the deductible or towards a medical savings account. Workers in their late 50s or early 60s would have the option of entering the Medicare program when they retired, or receiving a voucher to purchase health insurance or a medical savings account. The voucher amount would be inversely proportional to the amount they had contributed to the new individualized medical savings program. Workers' contributions to these accounts could be used to purchase Medigap insurance if they choose Medicare or to purchase catastrophic insurance if they chose MSAs if needed (under the provisions of the Balanced Budget Act of 1997, MSAs do include catastrophic insurance).

Individualized accounts might provide the beneficiary population with the financial security they value but only if there is a guarantee that the accumulated fund would be able to purchase adequate health insurance after retirement. The proponents of this approach argue that because the funds set aside for health insurance can be privately invested, this approach would provide a stronger foundation for retirees' financial security than the present system. Proponents have estimated that a relatively small rate of increase in investments could lead to fairly large accumulations in the accounts over a lengthy work life (relative to the HI trust fund, which is invested in government securities). By having each cohort save for its own post-retirement health care needs, the financial strains and political divisiveness that may accompany the retirement of the Baby

21 Other individualized savings models would eliminate all redistribution, including that among cohorts. These are discussed in a paper commissioned by the Academy's Study Panel on Medicare Financing (Chollet, 1998).

Boomers would be eliminated (Rice, 1998). The counter argument is that having a medical retirement account without any guarantee of what the account would actually be able to buy, relative to future health care needs and costs, does not provide the security that beneficiaries and their families want.

Equity across income groups is a major concern for individualized accounts. Whether a system of individualized accounts for the Medicare population includes a guarantee of some form of insurance defined in law is central in evaluating this restructuring option. Most models propose a combined "major medical" and outpatient care insurance plan with a high deductible amount (in the $2,500 — $6,000 range) and some cost-sharing, but more complete benefits for very high-cost episodes of care (Chollet, 1998). How the costs of the deductibles and coinsurance would be allocated among retirees and other payers, including Medicaid, is not clear. If these costs were to be transferred mainly to beneficiaries and their families, serious inequalities in access to health care could develop.

There are several issues to consider in regard to questions of equity, including how the individualized accounts would work for people who are not in, or are in and out of, the workforce during the years in which they were supposed to be contributing to these accounts, how much pooling or redistribution of the invested funds is envisioned, and how much responsibility would be borne by Medicaid (or other programs) for individuals who have not accumulated enough to pay for adequate insurance. If additional savings (above the cohort-standardized amount) were permitted, or individual investment decisions had different outcomes, some individuals would end up with accounts that are significantly larger than others. Because plans would be priced competitively, price differences would emerge across markets, and minimum benefit plans would cost different amounts in different regions. This could lead to substantial variations in beneficiaries' access to affordable health insurance. Without effective risk adjustment, competition among plans could also lead to significant problems of adverse selection (Chollet, 1998).

The logic of individualized accounts is that this approach takes maximum advantage of market efficiencies. Administered pricing systems are eliminated, and providers work directly with the insurers to establish payment rates. There are, however, many questions about the administrative efficiency, as well as the regulatory and oversight requirements, for a system of individualized accounts. How individualized accounts might be structured is not clear; as discussed in Chollet's work for the Study Panel on Medicare Financing (1998), options include 1) individual accounts managed exclusively by the individual; 2) individual accounts with limited federal oversight of investment options and practices; or 3) some combination of central and individual accounts. Managing tens of millions of individual medical savings accounts, including those of low-wage and seasonal workers, part-time workers, people with multiple jobs, and people who move in and out of the labor market for health reasons could be very expensive. There are also major administrative inefficiencies associated with making a transition from the current Medicare program to a system of individualized accounts. Both systems would have to be maintained for a considerable period of time.

The affordability of an individualized savings approach over time hinges on what happens to health care costs over time. Under the assumptions employed by its advocates, the incentives built into a medical savings account system, coupled with market competition, would significantly reduce the rate of increase in health care spending. The Saving / Gramm / Rettenmaier model assumes that the long-term growth rate in Medicare would be only 0.1 percent more that the consumer price index rate of inflation (Chollet, 1998). There is no way to know if this degree of savings is realistic, given unforeseeable changes in medical technology and the demand for medical care.

A system of individual accounts presents a series of problems related to accountability and oversight. The underlying premise is that individuals wish to assume, and will assume far more responsibility for their own retirement savings, including savings for their post-retirement health insurance. How these investment could or should be regulated — to protect investors against excessive administrative costs, gaming, fraud, etc, or against extreme risk-taking that could jeopardize their savings — is not well defined in models. It is clear, however, that there are far more opportunities for problems to develop in such a diffuse, decentralized system, particularly for individuals with limited experience or expertise in financial investing. As with voucher approaches, maintaining standards for both the reasonableness of covered services as well as accountability for quality of care and consumer protection would also be extremely difficult in a highly competitive, individualized system (Daniels and Sabin, 1998).

The sustainability of an individualized system obviously rests on the ability of individuals to save enough to pay for the costs of health care in the future. If investments are prudent and the financial markets are healthy, individual accounts might work well for (at least some) individual investors. If investment earnings outpaced increases in the costs of medical insurance over time, and the system, or some other system working in tandem (such as Medicaid), provided a backstop for individuals who have not saved enough to pay for adequate health insurance, the system might be sustainable, if potentially expensive for the public backstop program. These are, however, very big “ifs”. If Medicaid (or some other public program) bore the risk for those individuals for whom the individual accounts did not work, costs would simply have been shifted onto another program that might not be sustainable over time, and shifted philosophically from an insurance program (Medicare) to what is perceived as the welfare sector.

There are real tradeoffs between the increased individual liberty imputed to an individualized account scheme, and the constraints that would be placed on individuals as they assume more responsibility for paying for their health care. Buying just the right kind of insurance that meets an individual’s health care needs and preferences is a highly attractive concept that resonates with basic American values. Without carefully-structured regulation and oversight, however, individuals with limited resources and / or extensive health care needs could not be protected in a market-based system. Even the knowledgeable and prudent wage-earner might find it difficult to choose the health insurance products that would, in retrospect, work best for him as (say) an accident victim

at 70, or a stroke patient at 80, an Alzheimers patient at 90, or a healthy centenarian (see Chapter 2).

CONCLUDING OBSERVATIONS

In the Panel's view, none of the approaches to Medicare reform under serious consideration by policymakers can increase the health and financial security of beneficiaries and their families and simultaneously solve the problem of increasing health care costs in an aging society. Judgements about the right course to take have to weigh the importance of meeting the program's basic goals against other political, economic and social priorities.

Incremental fixes that increase beneficiary cost-sharing can delay the insolvency of the Medicare HI Trust Fund, but could also undermine the basic protections that the program was intended to provide. Simply adjusting program revenues to shore up the HI Trust Fund also fails to address the fundamental problem of health care costs, and how, as a society, we want decisions about access and quality of care.

Modernizing the Medicare program, by redesigning the benefits package, making fundamental changes in its administration and operations, and making sure that program eligibility makes sense given the demographics of the retiree population, could begin the process of establishing an infrastructure that can help support a more efficient health care system that serves the needs of the elderly and disabled. This is no easy task. It means taking the lead in research and development of methods of managing health care effectively, regulating markets, and helping beneficiaries make good decisions in a complex marketplace. Building a "better and smarter" Medicare program in an era in which government is often assumed to be the enemy will be difficult. Between the lines, much of the debate about the future of Medicare is about whether a major public program can be administered efficiently. To be fair, policy makers need to recognize that Medicare has not yet had much of a chance to do what needs to be done. The reform debate needs to include an objective discussion of the pros and cons of allowing Medicare to use more of the management and administration tools available to the private sector organizations that are reshaping health care markets across the United States.

The two approaches to more fundamental redesign of Medicare — structured competition (including both premium support models and vouchers) and pre-funded individualizing Medicare accounts — are rooted in the notion that the private marketplace can do a better job of controlling health care costs. In this view individuals, given appropriate incentives, will ultimately make better decisions about health care in a market system than they have in systems where they are at least partially shielded from the real costs of health care. Both these approaches to reform approaches transfer some portion of risk for health care costs from the government to individuals, who are asked to make choices about health insurance and the use of health care services based on tradeoffs between cost and quality. In the case of both vouchers that are not linked to defined benefits and individualized accounts, there are no assurances that beneficiaries will be able to purchase any health insurance that provides the access to care and protection against financial catastrophe that Medicare was originally created to provide. These proposals also assume a basic level of sophistication regarding Medicare coverage and the

purchase and use of health insurance that current research suggests simply is not there. To enable beneficiaries to make good choices, and to be accountable to taxpayers, restructuring options that depend on the market to control health care costs may require new local, regional and national information and oversight systems. This could increase, rather than decrease, government involvement in health care markets.

The Panel sees some of the current debate to be counterproductive, diverting attention from the value of Medicare past and present. We believe that the American people have accomplished a great deal by solving problems of health care for the elderly through social insurance — including universal coverage, objective standards of qualification, no application of means tests, avoidance of financial destitution, creation of a sense of security and belonging, and acceptance of mutual obligations by the working population. Medicare has dignified the elder generation. It serves families of all ages: it is a promise to workers for their own retirement or disability, and a safeguard for young and middle-aged family members with sick or disabled grandparents, parents, or other relatives or friends who may depend on them. There is no doubt that Medicare's delivery system and benefit structure need modernizing, to take better account of the elderly population's health care needs, to create efficiencies, and to reflect changes in the organization of the health care delivery system. But as we evaluate options for restructuring the Medicare program, we should remember what we have accomplished, and what we stand to lose, as well as gain, by change.

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APPENDIX A:
Tables and Figures

Table 1-1

Medicare Enrollment Demographics, September 30, 1997

Demographic	Enrollment	Percent
Total	**38,341,718**	**100.0%**
Age		
Under 65 years old (disabled)	4,786,419	12.5%
65-74 years old	17,938,687	46.8%
75-84 years old	11,574,238	30.2%
85 years old and older	4,042,374	10.5%
Gender		
Male	16,440,559	42.9%
Female	21,901,159	57.1%
Race		
White non-Hispanic	32,647,685	85.1%
Black non-Hispanic	3,471,381	9.1%
Hispanic	873,093	2.3%
Other	1,158,719	3.0%
Unknown	190,840	0.5%
Area of Residence		
Urban/Suburban	28,849,132	73.4%
Rural	10,391,271	26.4%
Unknown	46,190	0.1%

Note: Figures for Total, Age, Gender, and Race are based on data from 9/30/97. Figures for Area of Residence are based on data from 3/29/97.

Source: National Academy of Social Insurance, based on data from HCFA (Office of Information Services, Enterprise Database Group, Division of Information Distribution), 1998.

Table 1-2

Persons Served and Program Payments for Medicare Beneficiaries, by Demographic Characteristics: Calendar Year 1995

Demographic Characteristic	Persons Served (in thousands)	Persons Served1 (% of Total)	Premium Payments[1] (% of Total)	Average Program Payment Per Enrollee[2]	Urban Program Payments[3], Per Enrollee[2]	Rural Program Payments[3], Per Enrollee[2]
Total	30,423	100.0%	100.0%	$4,667		
Sex						
Male	12,264	40.3%	43.2%	4,721		
Female	18,159	59.7%	56.8%	4,627		
Age						
Under 65 Years	3,495	11.5%	13.2%	4,960		
65-74 Years	13,829	45.5%	36.5%	3,548		
75-84 Years	9,560	31.4%	34.8%	5,576		
85 Years or Over	3,540	11.6%	15.5%	6,950		
Race[4]						
White	26,476	87.0%	83.5%	4,545		
Non-White	2,582	8.5%	12.0%	4,258		
Medicare Status						
Aged	26,815	88.1%	83.9%	4,489		
Disabled	3,344	11.0%	10.2%	3,975		
With ESRD[5]	264	9.0%	5.8%	37,611		
MSA Type[6]						
Urban	22,302	73.3%	77.4%	4,841		
Rural	7,809	25.7%	22.0%	4,052		
Area of Residence						
Northeast[7]				$5,108	$5,251	$3,968
Midwest[8]				4,265	4,605	3,567
South[9]				4,875	5,041	4,527
West[10]				4,747	5,027	3,732

1 Does not include beneficiaries who did not receive Medicare services or beneficiaries who received covered services but for whom no program payments were reported during the year.

2 Beginning with 1994, the utilization rates per 1,000 enrollees do not reflect managed care enrollment; that is, Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates.

3 The classification of counties into urban or rural groups is based on the list of metropolitan statistical areas (MSAs) defined by the Office of Management and Budget. For the purpose of this report, a rural area of residence is defined as an MSA with fewer than 50,000 resident population.

4 Excludes unknown races.

5 ESRD is end stage renal disease; includes aged and disabled beneficiaries with ESRD as well as those who qualify for Medicare with ESRD status only.

6 MSA is metropolitan statistical area; excludes outlying areas.

7 Includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

8 Includes Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin.

"9 Includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.

10 Includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming.

Source: National Academy of Social Insurance, based on data from the Health Care Financing Review, 1997 *Statistical Supplement*, p. 40-41, Tables 14-15.

Table 1-3

Summary of Out-of-Pocket Health Care Spending for Non-Institutionalized Medicare Beneficiaries Age 65 and Over, 1997

		Not Medicaid-Enrolled		Medicaid Enrollees	
	TOTAL	Fee-for-Service	HMO enrollees	Full year	Part Year
Average Out-of-Pocket Health Care Spending	$2,149	$2,454	$1,775	$377	$1,758
Health Services Costs					
Hospital	$150	$171	$108	$16	$266
Physician/Supplier/Vision	$378	$407	$372	$135	$452
Dental	$166	$183	$193	**	**
Prescription Drugs	$351	$387	$330	$96	$337
Health Insurance Costs					
Medicare Part B Premium Contributions	$439	$486	$508*	$0	$296
Private Insurance/HMO Premium Contributions	$665	$818	$264	$72	$354

Note: Out-of-Pocket health care spending excludes Medicare Part A payroll taxes, home health care services and nursing facility care.

* Insufficient number of observations for presenting a statistically significant projection.

** The average Part B premium contribution represents an average premium cost over the entire year. The average contribution for HMO enrollees and fee-for-service enrollees differs because of differences between each group in the number of months that the average enrollee was in Medicare.

Source: AARP Public Policy Group and the Lewin Group, *Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*, p. 7, Table 2.

Table 1-4

Out-of-Pocket Health Costs for Medicare Beneficiaries Not Enrolled in Medicaid, by Type of Cost, 1997

	Fee-for-Service		
	Private Insurance	Medicare Only	HMO
All Beneficiaries (age 65 and over)	$2,610	$1,735	$1,775
Health Services Costs			
Hospital	$109	$454	$108
Physician/Supplier/Vision	$401	$436	$372
Dental	$203	$92	$193
Drugs	$408	$291	$330
Health Insurance Costs			
Medicare Part B Premium Contributions	$492	$462	$508
Private Insurance/HMO Premium Contributions	$997	$0	$264

Note: Out-of-pocket health care spending excludes home health services and nursing facility care.

Source: AARP Public Policy Group and the Lewin Group, *Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*, p. 13, Table 4.

Table 1-5

Average Out-of-Pocket Health Costs for Non-institutionalized Medicare Beneficiaries Age 65 and Over, by Income Status, 1997

	Not Medicaid-Enrolled			
	Total	Fee-for-Service	HMO enrollees	Full year Medicaid Enrollees*
All Beneficiaries (age 65 and over)	$2,149	$2,454	$1,775	$337
Income Status				
Poor (below 100% of poverty)	$1,465	$2,299	$1,603	$340
Near-Poor (100%-125% of poverty)	$1,663	$2,287	$1,406	$198
Low Income (126%-200% of poverty)	$2,048	$2,330	$1,509	$389
Middle Income (201%-400% of poverty)	$2,305	$2,477	$1,852	$374
High Income (over 400% of poverty)	$2,411	$2,585	$1,994	$399

Note: Out-of-pocket health care spending excludes home health services and nursing facility care. A small percentage of Medicare beneficiaries with Medicaid are reported here to have incomes above 200 percent of poverty. One reason this occurs is because the poverty level is based on family income, while Medicaid eligibility is based on individual income. Beneficiaries receiving Medicaid and living with family member may be included in the middle or high income groups because of their families' income level, although their own income qualify them for Medicaid assistance. Another explanation is that some beneficiaries may incur sufficiently high medical costs as to spend down their income and assets at some point during the year, thereby making them eligible for Medicaid.

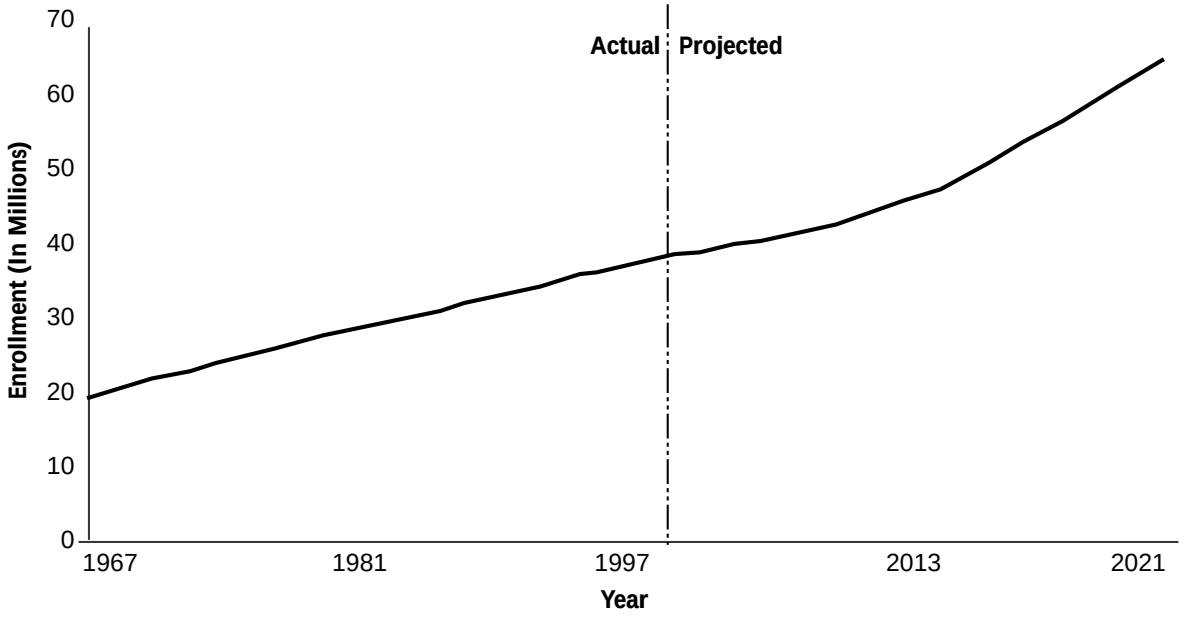
* Insufficient number of observations in each income group for presenting statistically significant projections for part-year Medicaid enrollees.

Poverty level for persons over age 65 in 1997 was $7,755 for individuals and $9,780 for couples.

Source: AARP Public Policy Group and the Lewin Group, *Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*, p. 11, Table 3.

Figure 1-1

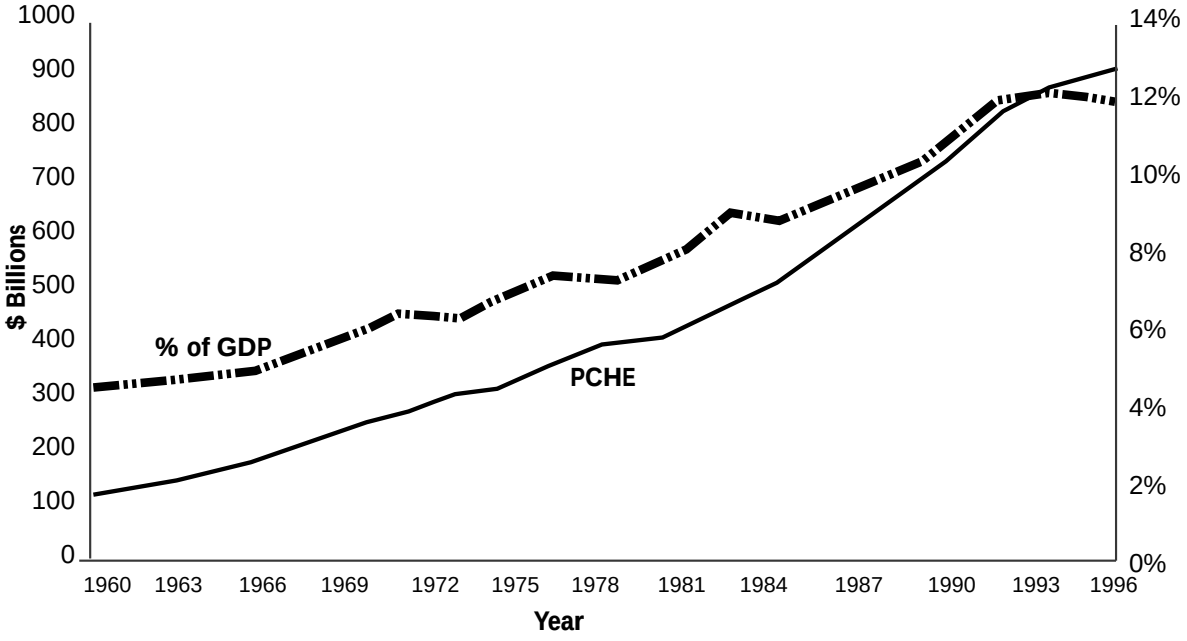
Medicare Enrollment Over Time



Source: National Academy of Social Insurance, based on data from the *Health Care Financing Review, 1997 Statistical Supplement,* p. 23, Table 5, HCFA (Office of the Actuary), December 31, 1997, and HCFA (Division of Information Distribution), 1998.

Figure 1-2

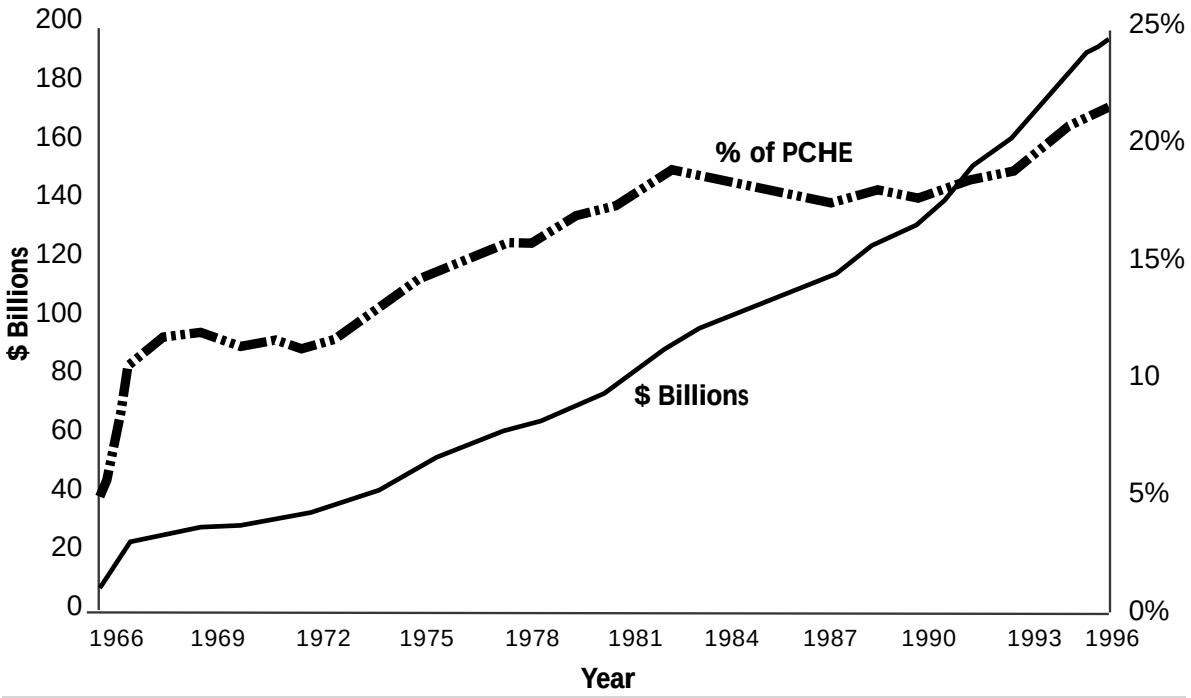
Personal Health Care Expenditures (PHCE) in Real 1996 Dollars and as a Percentage of GDP



Source: National Academy of Social Insurance, based on data from HCFA (Office of the Actuary), the Department of Commerce (Bureau of Economic Analysis), and the Department of Labor (Bureau of Labor Statistics), 1998.

Figure 1-3

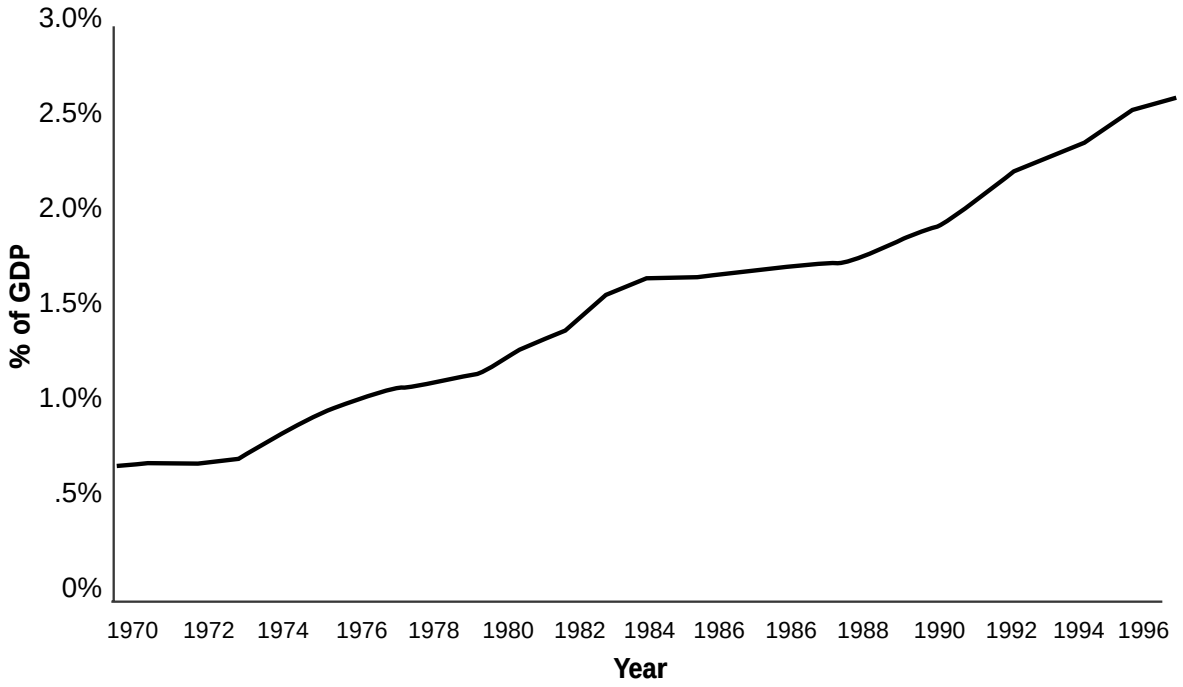
Medicare Expenditures in Real 1996 Dollars and as a Percentage of Personal Health Care Expenditures



Source: National Academy of Social Insurance, based on data from HCFA (Office of the Actuary), the Department of Commerce (Bureau of Economic Analysis), and the Department of Labor (Bureau of Labor Statistics), 1998.

Figure 1-4

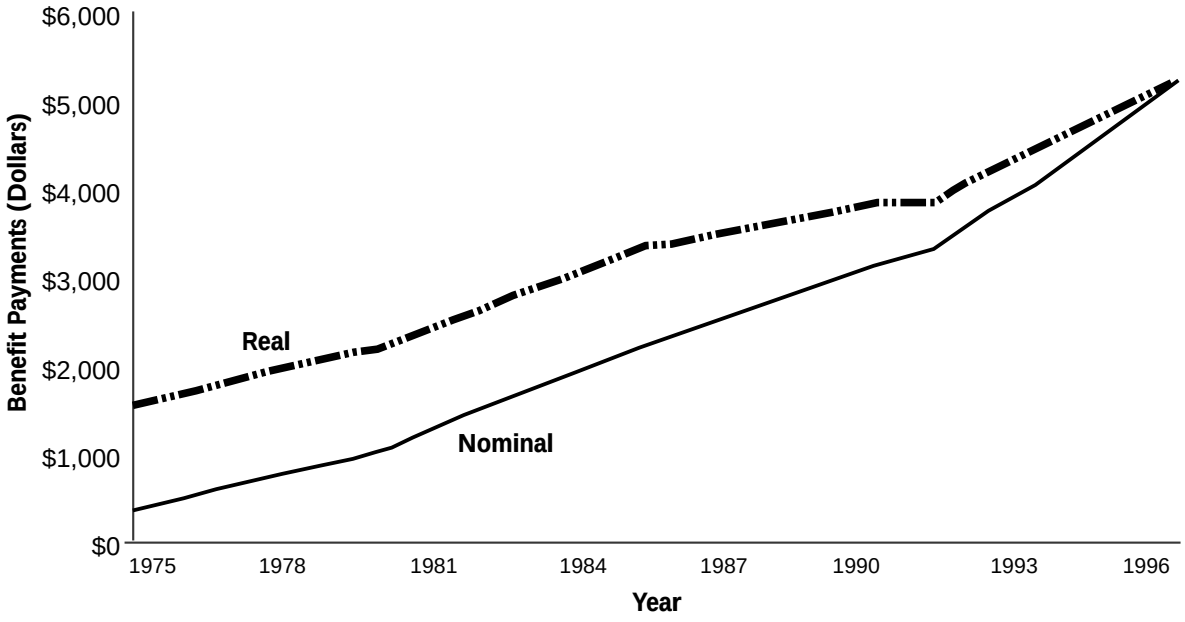
Medicare Expenditures as a Share of Gross Domestic Product



Source: National Academy of Social Insurance, based on data from HCFA (Office of the Actuary) and the Department of Commerce (Bureau of Economic Analysis), 1998.

Figure 1-5

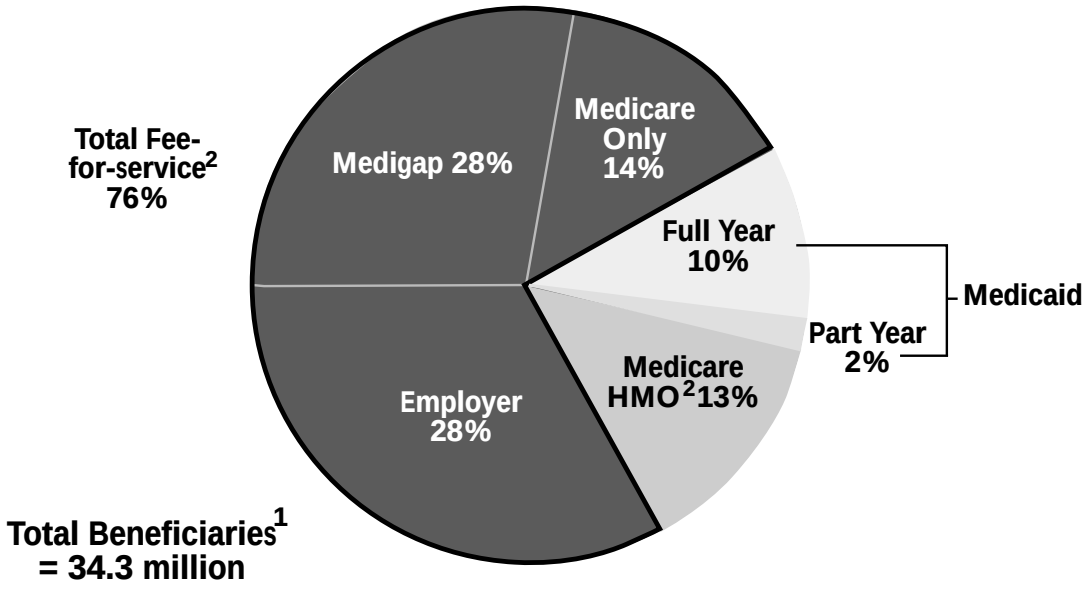
Average Annual *Per Capita* Medicare Benefit Payment in Nominal Dollars and Real 1996 Dollars



Source: National Academy of Social Insurance, based on data from the U.S. Congress, House of Representatives, Committee on Ways and Means, *1996 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, prepared by members of the Committee on Ways and Means Staff, Comm. Pub. No. 104-14 (Washington, DC: U.S. Government Printing Office, November 4, 1996), p. 135-136, Table 3-2, and the U.S. Department of Labor, Bureau of Labor Statistics, 1998.

Figure 1-6

Type of Coverage for Medicare Beneficiaries[1], 1997



Note: Percentages may not sum to 100% due to rounding.

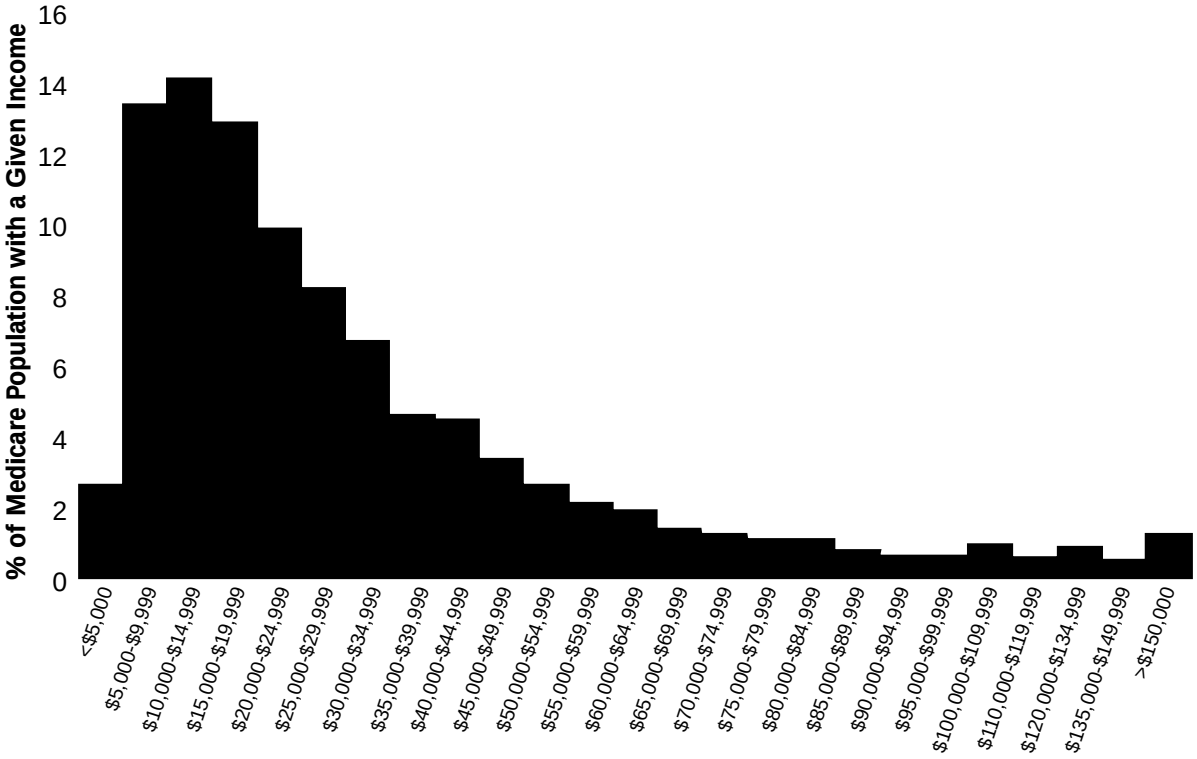
1 Includes non-institutionalized beneficiaries age 65 and older.

2 Not enrolled in Medicaid.

Source: AARP Public Policy Group and the Lewin Group, *Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: Further Analysis of 1997 Projections*, p. 4, Figure 1.

Figure 1-7

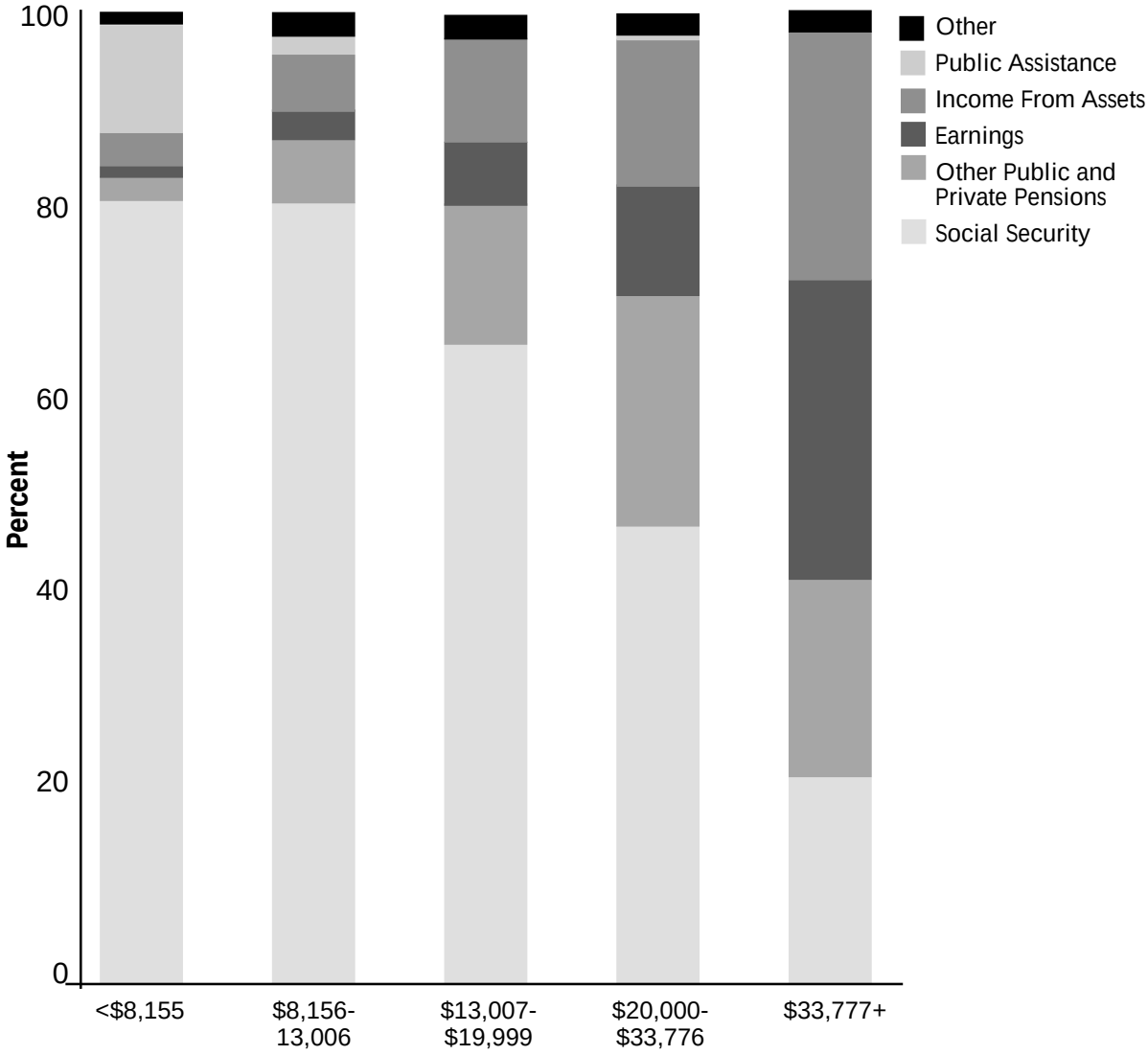
Projected Family Income Distribution of Medicare Beneficiaries, 1998



Source: An analysis of the 1997 Current Population Survey done by Marilyn Moon and colleagues at the Urban Institute, 1998.

Figure 1-8

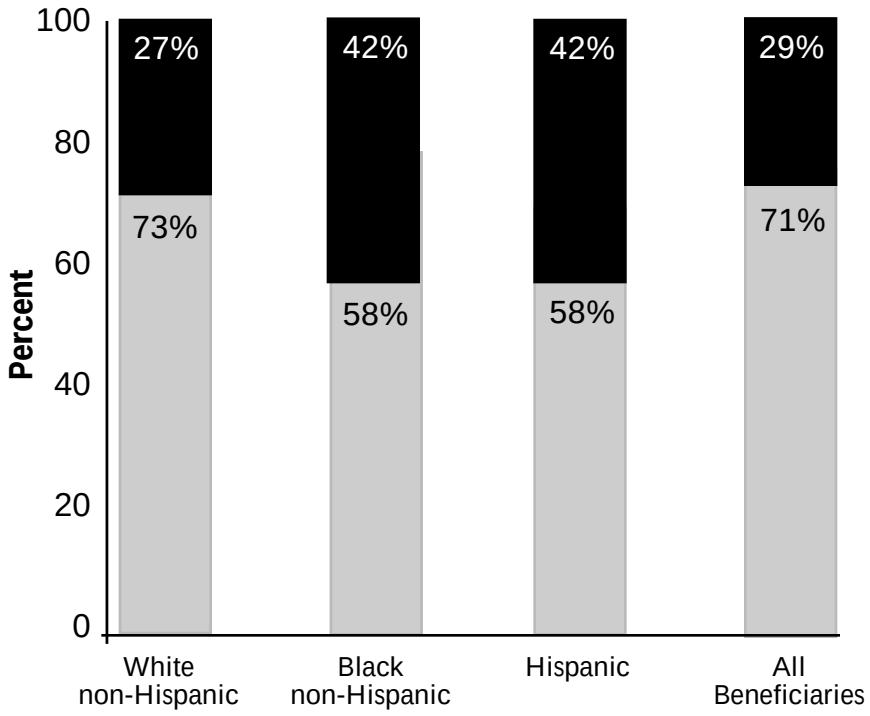
Sources of Family Income for Persons Age 65 and Over by Quintiles of Family Income, 1996



Source: National Academy of Social Insurance, based on data from the Social Security Administration, Office of Research, Evaluation and Statistics, *Income of the Population 55 or Older*, 1996, SSA Pub. No. 13-11871 (Washington, DC: April 1998).

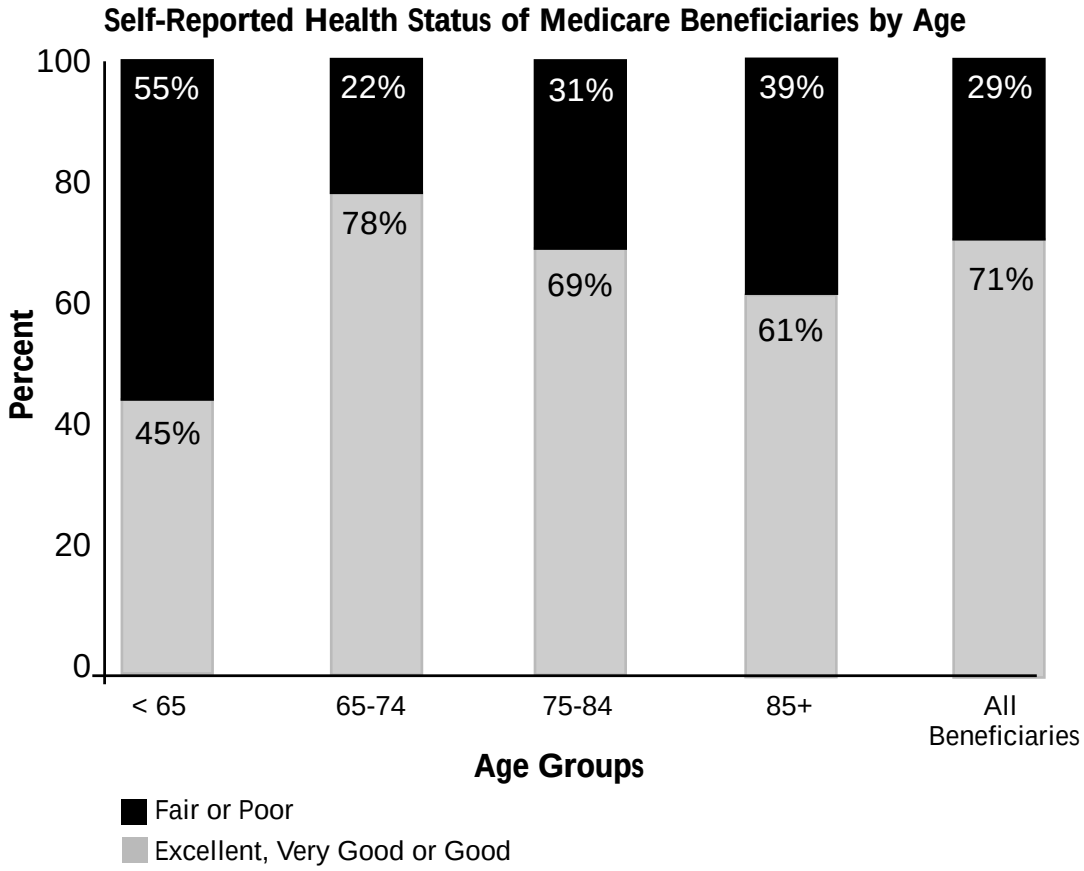
Figure 1-9

Health Status by Race



Source: National Academy of Social Insurance, based on data from Laschober, M.A., and Olin, G.L., *Health and Health Care of the Medicare Population: Data From the 1993 Medicare Current Beneficiary Survey* (Rockville: MD; Westat, Inc., November 1997) p. 36, Table 2.3.

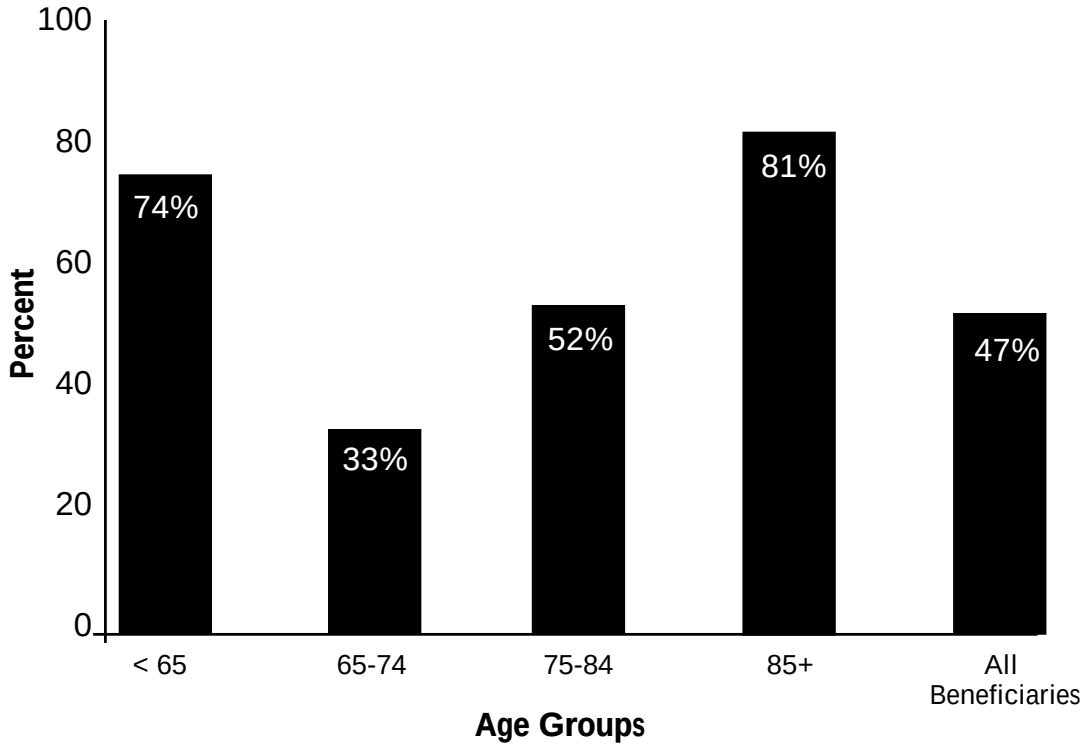
Figure 1-10



Source: National Academy of Social Insurance, based on data from Laschober, M.A., and Olin, G.L., *Health and Health Care of the Medicare Population: Data From the 1993 Medicare Current Beneficiary Survey* (Rockville: MD; Westat, Inc., November 1997) p. 32, Table 2.1.

Figure 1-11

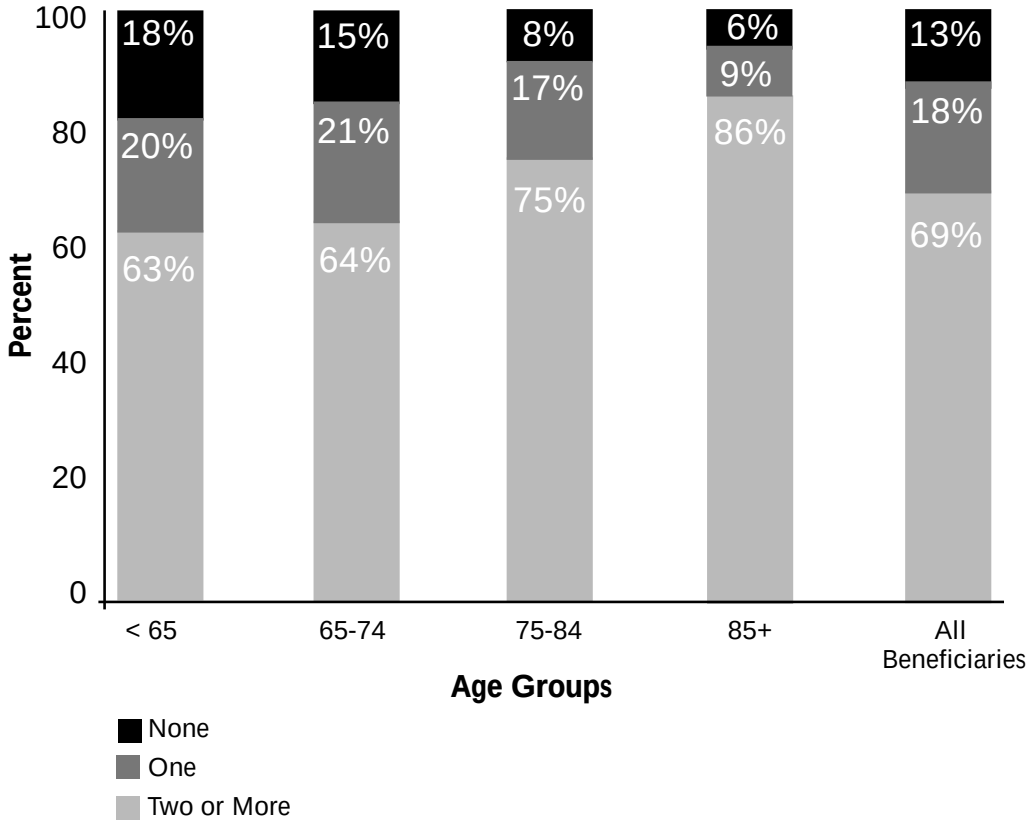
Percentage of Medicare Beneficiaries With Any Functional Limitations That Restrict Activities Related to Independent Living or Personal Care



Source: National Academy of Social Insurance, based on data from Laschober, M.A., and Olin, G.L., *Health and Health Care of the Medicare Population: Data From the 1993 Medicare Current Beneficiary Survey* (Rockville: MD; Westat, Inc., November 1997) p. 32, Table 2.1.

Figure 1-12

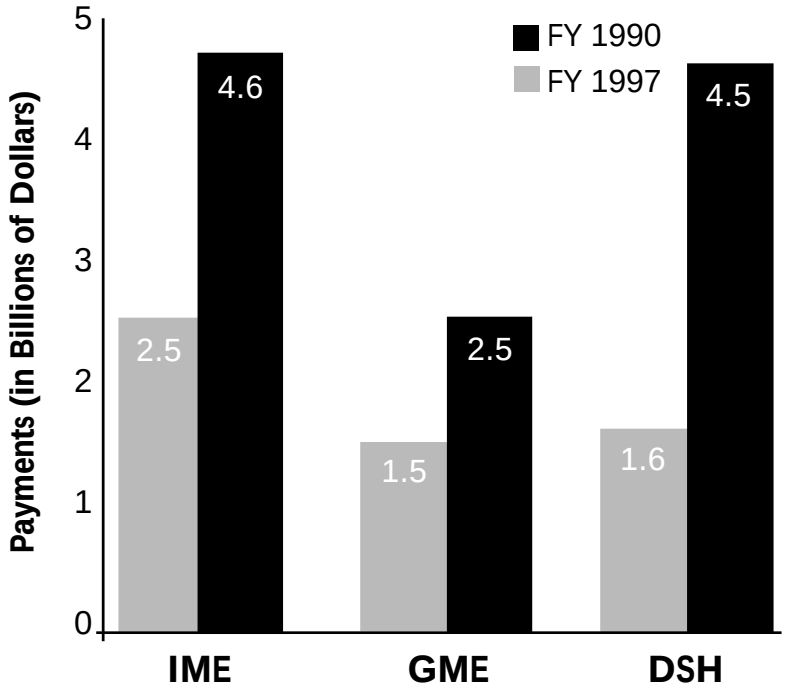
Self-Reported Number of Chronic Health Conditions by Age Group



Source: National Academy of Social Insurance, based on data from Laschober, M.A., and Olin, G.L., *Health and Health Care of the Medicare Population: Data From the 1993 Medicare Current Beneficiary Survey* (Rockville: MD; Westat, Inc., November 1997) p. 34, Table 2.2.

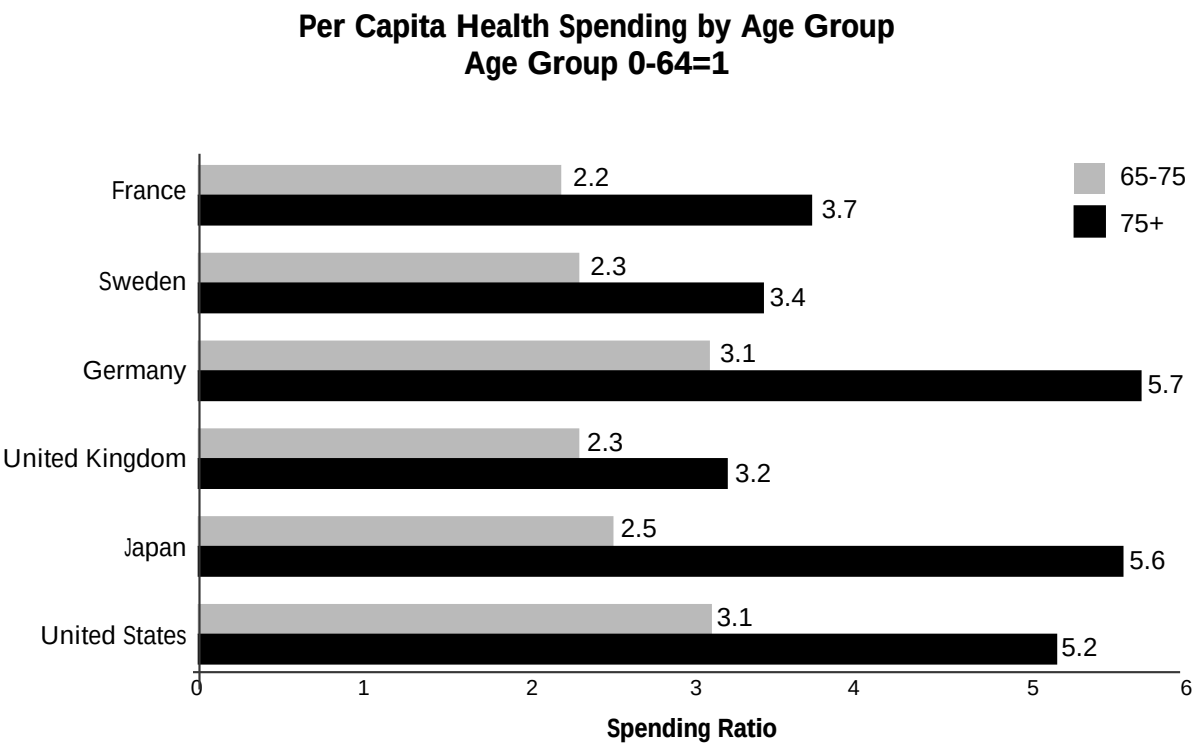
Figure 1-13

Medicare Payments for Direct Graduate Medical Education (GME), Indirect Medical Education (IME) and Disproportionate Share Hospitals (DSH), FY 1990 and FY 1997 (In Billions of Dollars).



Source: National Academy of Social Insurance, based on data from the Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy. Volume I: Recommendations* (Washington, DC: MedPAC, March 1998), p. 116, Figure I-12-1 and the Physician Payment Review Commission, *Medicare Prospective Payment and the American Health System: Report to Congress* (Washington, DC: ProPAC, June 1990) p. 23.

Figure 1-14



Source: Reinhardt, U., "Can America Afford Its Elderly Citizens? Thoughts on the Political Economy of Sharing," *Princeton Conference on Medicare—Remarks* (Princeton, NJ: Princeton University, February 28, 1997).

Figure 1-15a

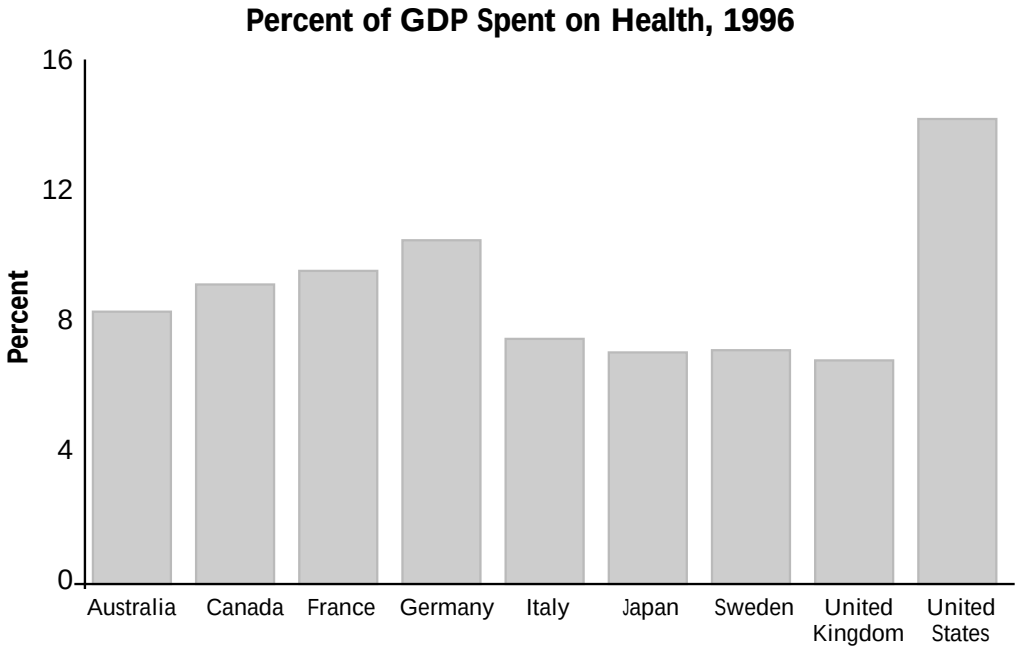
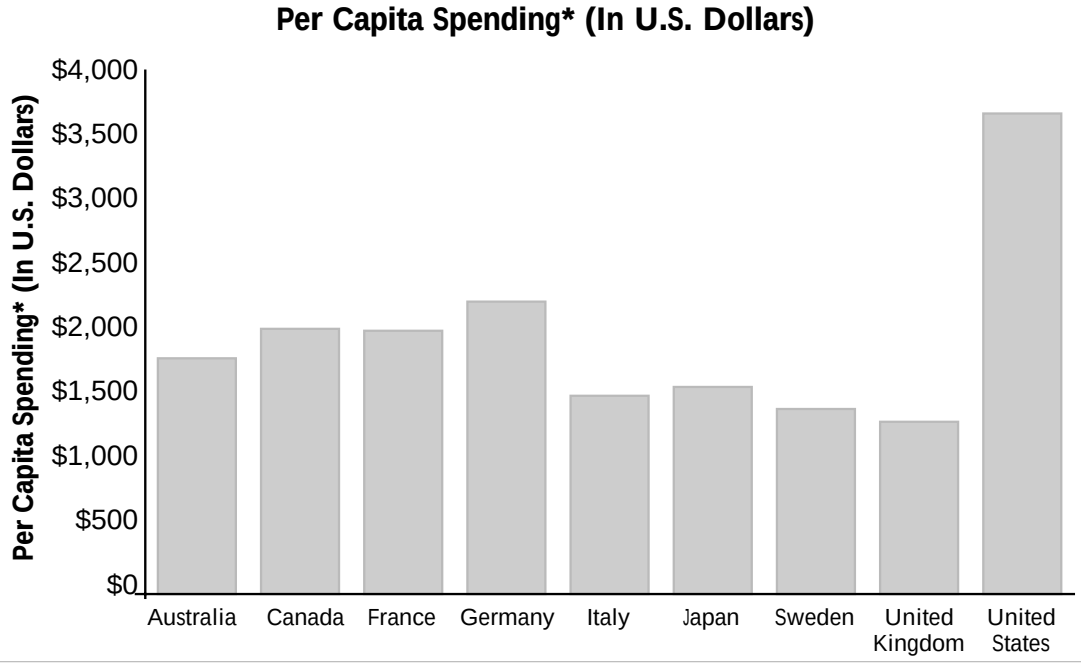


Figure 1-15b



Note: GDP is Gross Domestic Product. Data for Percent of GDP Spent on Health and Per Capita Spending Dollars for Japan are from 1995. Data for Percent of GDP Spent on Health for Sweden is from 1995.

* Per capita spending is adjusted for purchasing power parities. Purchasing power parities express the rate at which one currency should be converted to another for a given expenditure to purchase the same set of goods and services in both countries.

Source: National Academy of Social Insurance, based on data from Anderson, G.F., In Search of Value: An International Comparison Of Cost, Access, And Outcomes, Health Affairs, 16(6): p.164, Exhibit 1.

APPENDIX B:
National Academey of Social Insurance Medicare Poll and Focus Group Research

The national poll for the Study Panel on Medicare's Larger Social Role was conducted between May 27 and June 7, 1997, by the firm National Research, Inc. A random digit dialing protocol was used to poll 1,000 respondents from across the continental United States. Each telephone interview took about 10 minutes. A sample size of 1,000 yields results for the full sample of respondents that are statistically accurate within 3 to 4 percent at the 95 percent confidence level. Respondents were also asked about a set of broad policy alternatives directed at shoring up or restructuring Medicare. The Panel wanted to see how public values are reflected in assessments of possible changes to Medicare, and in what ways.

Interpreting the poll data and comparing the responses to those in other polls led to a second set of questions about public perceptions, values, and understanding of the policy options. Some of these were explored in a series of ten focus groups conducted in three different areas of California in February, 1998. The focus group project was supported by the California Health Care Foundation. Five were held in the Los Angeles area, three in San Jose, and two in the Sacramento area. Seven focus groups were comprised of Medicare beneficiaries aged 65 or older; of these two were conducted in Spanish, and one in Chinese (Cantonese); three groups were comprised of people aged 50-64 (predominantly not beneficiaries, but including several disabled persons in each group who were receiving Medicare benefits). The groups included low and middle income beneficiaries (about one third with incomes under $9,000). The groups were structured to address two major topics: beneficiaries' understanding of and experiences with Medicare and the Medicare managed care options available to them in California; and their views about the future of Medicare, including the expansion of plan options, cost sharing, and individual and family responsibilities for health care now and in the future. The focus groups were conducted by the Kleimann Communication Group under contract to the National Academy of Social Insurance; Academy staff participated in the design of the moderator's guide and as educators in the sessions. A description of the methodology, including moderator's guides, educational materials used in the groups, and recruiting profiles are included in "Medicare Choices in California," Report to the California HealthCare Foundation, Grant # 97-501, submitted by the National Academy of Social Insurance, June, 1998.

APPENDIX C: Acknowledgements

The National Academy of Social Insurance and its Study Panel on Medicare's Larger Social Role gratefully acknowledges the assistance provided by the following individuals to the Panel's work. However, any errors or omissions the report may contain are the responsibility of the Study Panel and staff.

Irma Arispe
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Alpha Center

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Paula Higger,
Health Care Financing Administration

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Kleimann Comunication Group

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Kleimann Communications Group

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Health Care Financing Administration

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Urban Institute

Ron Topper,
Health Care Financing Administration

Mary Carol Weaver
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David Wood,
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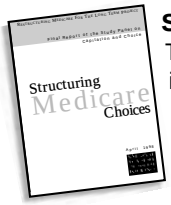
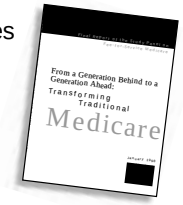
Medicare Today and Tomorrow: Views from California
February 1999, 30 minutes. $7.00

This videotape was drawn from a series of focus groups with current and soon-to-be Medicare beneficiaries in California in 1998. In Part 1, participants describe their experiences navigating a health care system where managed care and choice among health plans are firmly established. In Part 2, participants discuss their concerns about Medicare and discuss the pros and cons of a range of Medicare reform proposals.



Structuring Medicare Choices, April, 1998. 123 pages, $15.00
This final report of the Study Panel on Medicare Capitation and Choice analyzes steps that should be taken to improve Medicare's capitated payment options and to examine how health care plans can compete for enrollees based on their ability to control costs and offer quality services. The report develops a set of recommendations designed to make Medicare options flexible enough to take care of local market efficiencies while ensuring appropriate and necessary care and a wider choice of health plans for beneficiaries.

From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare,
January 1998, 62 pages, $15.00



This final report of the Study Panel on Fee-for-Service Medicare analyzes the key characteristics and difficulties of the fee-for-service (FFS) program, management strategies suggested by clinical research and private insurance that Medicare could test, and policy alternatives to allow such innovation in FFS Medicare and transform it from a traditional bill-paying entity to a program more accountable for the quality of health care and costs of services provided to beneficiaries.

Securing Medicare's Future: What are the Issues? March 1997, 48 pages, $5.00.

The Interim report of the Academy's Medicare Steering Committee examines the critical issues facing this social insurance program in the 21st century. The report identifies three main areas that will require attention in order to keep the program viable for the next generation.

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Criteria for Evaluation Medicare Reform Options

Financial Security: *The degree to which Medicare (under the current program or as a reformed program) provides financial security to the elderly and disabled (and their families across generations) as they incur costs for medical care.*

Equity: *The degree to which Medicare is able to serve all populations fairly, including beneficiaries and future beneficiaries, regardless of age, health, gender, race, income, place of residence or personal preferences.*

Efficiency: *The ability of Medicare to promote the use of appropriate and effective medical care for the beneficiary population, i.e. care that is technically efficient and minimizes the use of ineffective or unnecessary services, is consistent with the preferences of patients, and recognizes the real costs of services. Efficiency also includes the degree to which administration of the program is timely and responsive to the needs of consumers and providers, and the application of financing methods that are not unnecessarily burdensome.*

Affordability over time: *The degree to which the costs of Medicare can be borne without diverting public revenues needed for other important public priorities.*

Political accountability: *The degree to which the information needed to determine whether the program is achieving its goals is available, and mechanisms are in place to identify problems and institute corrective actions in a timely manner that is fair to all beneficiaries, to providers, and to taxpayers.*

Political sustainability: *The degree to which the Medicare program enjoys the support of the American population, regardless of the state of the economy, political climate, or social atmosphere.*

Maximizing individual liberty: *The extent to which Medicare policies, including incentives structured to promote efficiency, allow individual beneficiaries to exercise their own judgment and individual preferences in making choices about their health care.*

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