

## Individualizing Medicare

By Deborah J. Chollet

### Summary

Despite the enactment of significant changes to the Medicare program in 1997, Medicare's Hospital Insurance trust fund is projected to be exhausted just as the baby boom enters retirement. To address Medicare's financial difficulties, a number of reform proposals have been offered, including several to individualize Medicare financing and benefits. These proposals would attempt to increase Medicare revenues and reduce Medicare expenditures by having individuals bear risk – investment market risk before retirement and insurance market risk after retirement. Many fundamental aspects of these proposals have yet to be worked out, including how to guarantee a baseline level of saving for health insurance after retirement, how retirees might finance unanticipated health insurance price increases after retirement, the potential implications for Medicaid of inadequate individual saving, and whether the administrative cost of making the system fair and adequate ultimately would eliminate any rate-of-return advantages from allowing workers to invest their Medicare contributions in corporate stocks and bonds.

### Introduction

The projected increases in Medicare costs stem not only from rising health care costs, but also from the retirement of the baby boom and longer expected lifetimes among the elderly. Concern about future program costs has generated a wide variety of proposals to restructure the program. This *Brief* examines one set of reform proposals: those that would establish individual lifetime savings accounts to finance health care after retirement. While a decision to individualize Medicare financing would not necessarily entail a change in the program's benefits, current proposals typically link reformed financing to reformed benefits — specifically, to a system in which retirees would choose among competing insurance plans which might not include the traditional public Medicare program.

### Proposals to individualize Medicare

In the current Medicare system, about half of the program's combined hospital and medical benefits are financed from worker contributions in the form of a

dedicated payroll tax and paid into a trust fund.

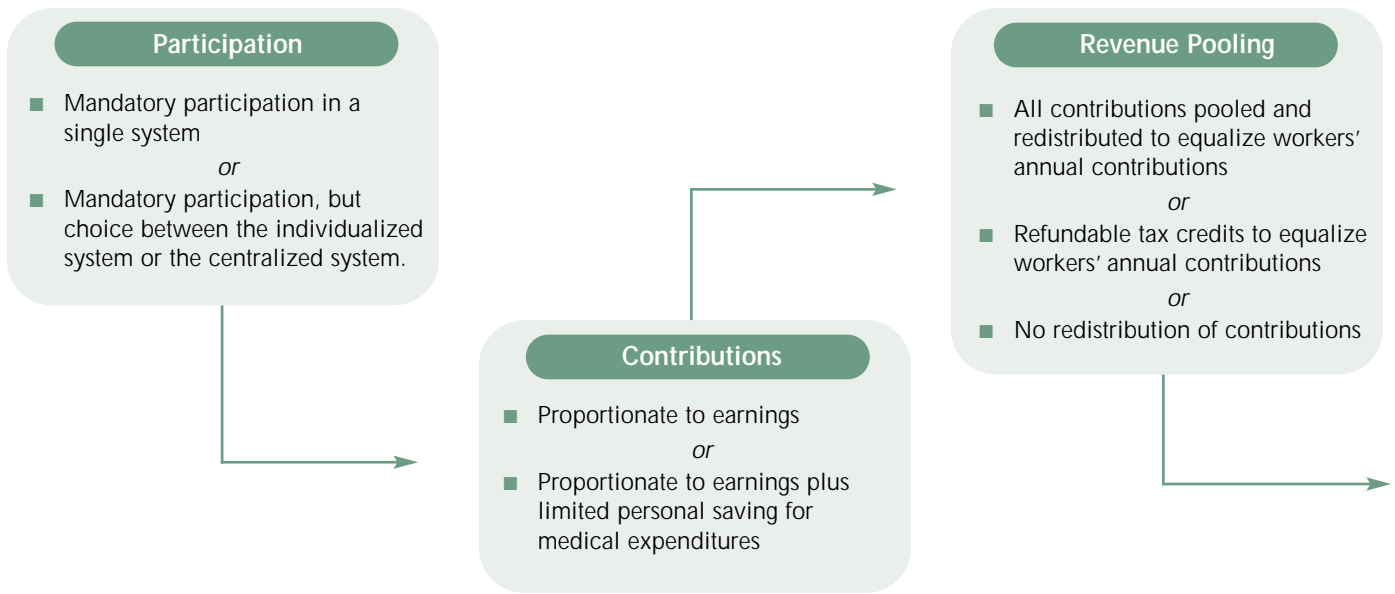
Medicare's statutory obligation to invest all trust fund assets in low-risk (but low-yield) U.S. Treasury debt minimizes investment risk, and the system generates the same basic level of insurance protection for current retirees regardless of differences in their lifetime contributions. Current proposals to individualize Medicare would attempt to retain some of the equity results of the current Medicare program. However, to improve the program's earnings and cost performance, they would have individuals bear risk – investment market risk before retirement and also insurance market risk after retirement.

The following sections discuss the major features of individualized Medicare financing – that is, a system in which workers would hold personal retirement health accounts and earn the greater rate of return available to assets held in corporate stocks and bonds. We then turn to the issues raised by individualized Medicare benefits – that is, a system in which retirees would choose among competing private health insurance plans that may offer different benefits and may charge

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Figure 1

Selected features of proposals to individualize Medicare or Social Security



different prices. In all of the proposals that combine individualized Medicare financing with individualized benefits, whether each worker’s accumulated retirement assets would be enough to purchase an insurance plan with equal or better benefits than today’s Medicare program is speculative. Various simulations indicate that the average retiree’s accumulated assets might be adequate. However, whether every retiree could afford the same basic benefits depends on whether and how assets might be redistributed at retirement and how a private Medicare insurance benefit would be priced.

### Individualized financing

This section discusses five major aspects of proposals to individualize Medicare financing:

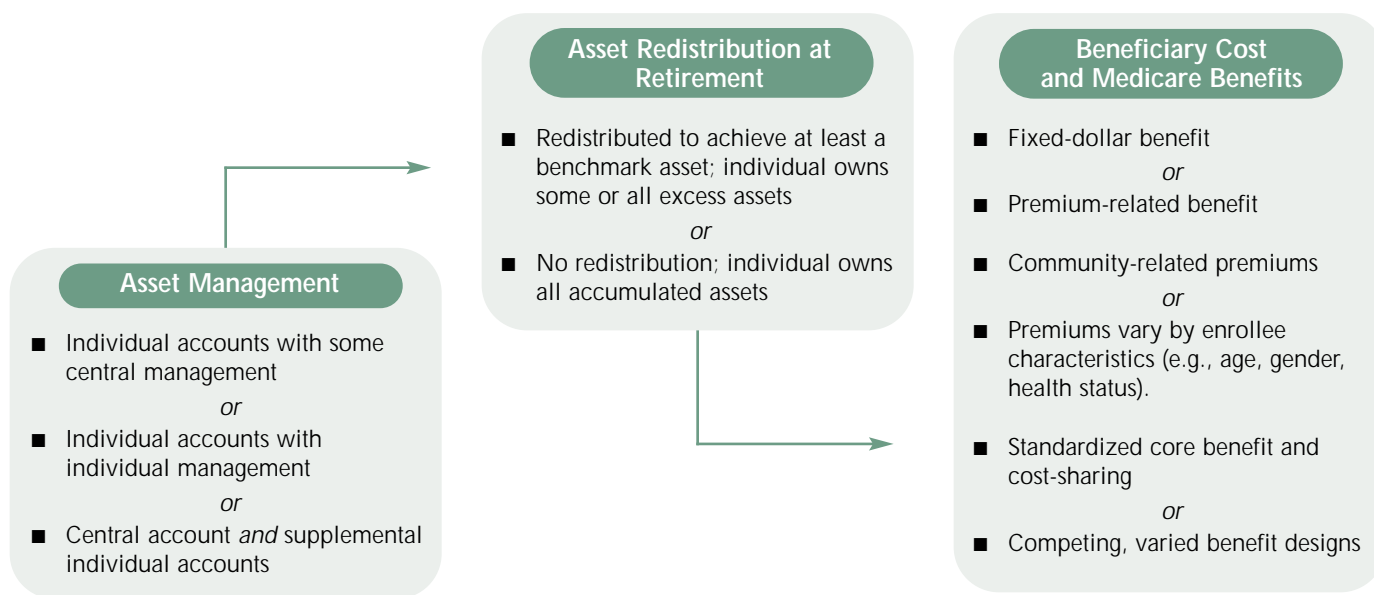
- (1) who would participate in the individualized system;
- (2) the level of worker contributions necessary to pay for future benefits;
- (3) how contributions might be pooled and redistributed to lower-wage workers;
- (4) how assets that accumulate in workers’ individual accounts would be managed; and
- (5) whether accumulated assets would be redistributed at retirement to offset workers’ unequal earnings on privately invested contributions.

In general, the options within each category could be combined with any of those in another category, and in ways that could differ from the specific proposals that have been offered. To highlight how interchangeable specific features of these proposals can be, the major features of key proposals to individualize Medicare financing, benefits or both are summarized, supplemented with some features from various proposals to individualize Social Security’s retirement income program, and arranged schematically in Figure 1. In Table 1, selected specific Medicare reform proposals that would individualize financing are summarized, as well as one proposal (generically called “premium support”) that would individualize Medicare benefits but not the program’s financing. The section concludes by summarizing the difficult problem of predicting net earnings on investment in an individualized system of Medicare financing.

**Participation.** The major proposals to reform Medicare financing all would retain mandatory participation in order to establish a baseline level of retirement health saving for each worker. Most proposals would require all workers to participate in the same system, as in the current Medicare program. However, one proposal (Ferrara, 1998) would allow individuals either to continue to participate in the current system or to select themselves out in favor of

Figure 1 (continued)

Selected features of proposals to individualize Medicare or Social Security



making contributions to a personal “health bank” account. This proposal is silent on whether and how individuals might reconsider and reverse their initial choice and transfer to the other system. If such a decision were irreversible, it could be a strong incentive for most workers to remain in the more traditional Medicare program. However, unrestricted freedom to reverse decisions about participation would raise the cost of the traditional program, since workers would reverse their decisions presumably to maximize their ultimate benefit.

**Contributions.** All of the major proposals assume workers would contribute a flat tax on wages to finance health care in retirement (as in the current Medicare program), and all assume that current contribution rates would not (or could not) rise above the levels paid by today’s workers and their employers. However, the actual tax rate would depend on at least three factors: (a) the expected cost of future benefits, (b) the extent to which future benefits are fully funded, and (c) how the transition from today’s pay-as-you go financing to greater funding of benefits for future retirees is financed.

Proposals to individualize Medicare generally assume that the program would be unified, combining

Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) benefits into a more conventional, integrated health insurance plan. In some proposals, this unified program would pay for a comprehensive health insurance benefit offered by competing managed care plans. Others envision only catastrophic insurance plans, with high deductibles and some additional cost-sharing, but with more complete benefits for very high-cost episodes of care compared to Medicare’s current benefit design. Still others envision the benefit paid as a voucher amount that may or may not be related to the local cost of insurance plans or enrollee characteristics (such as health status, age or gender). Each of these types of proposals claims that a reconfigured Medicare benefit would dramatically reduce the future cost of insuring retirees and, therefore, the payroll tax rate needed to finance benefits. However, because these proposals abandon Medicare’s current defined health-insurance benefit, beneficiaries would be individually at risk for financing costs after retirement that exceed their expectations and, therefore, their savings.

All proposals to individualize Medicare financing are rooted in concern about the high cost of pay-as-you-go financing of future Medicare benefits, and all envision a transition to full funding of these benefits. By

Features of Selected Medicare Reform Proposals

Proposal	Participation	Contributions	Asset Management	Asset Redistribution	Benefit
Premium support <sup>a</sup>	Mandatory universal participation, as in current law. (Age of eligibility would be increased to the Social Security retirement age.)	Flat percent of wages, as scheduled in current law.	As in current law, or a unified Medicare trust fund with central management.	Not applicable.	Fixed-dollar voucher, calculated as a percent of the national weighted average premium. Amount would be adjusted for factors including geographic area, enrollee health status, age, sex and income. Enrollees would choose among approved, competing health plans, including Medicare FFS. Private-plan benefits (beyond a core set) and cost sharing may vary.
Personal retirement insurance for medical expenses (PRIME) <sup>b</sup>	Mandatory universal participation above age 22 and (in 1998) age 43 or younger.	Flat percent of wages (1.10 - 3.31 percent) calculated within 10-year age cohorts to fund that cohort's future benefits.	Federally qualified individual accounts, individually selected and managed.	Aggregate cohort contributions would be redistributed to produce an equal (possibly age-adjusted) annual contribution for each cohort member.	High-deductible (\$2,500), comprehensive and competing private health insurance plans, and a limited menu of other options (e.g., HMO and lower deductible plans).
Retiree health accounts <sup>c</sup>	Mandatory universal participation, as in current law.	Flat percent of wages (2.15 percent).	Federally qualified individual accounts, individually selected and managed.	Contributions would be redistributed to produce an equal annual contribution for all workers.	
Health bank accounts <sup>d</sup>	Mandatory universal participation, as in current law.	Flat percent of payroll, as scheduled in current law.	Individually selected and managed accounts.	None.	Inflation-adjusted annuity to finance enrollee's selection among high-deductible (e.g., \$3,000), competing private health insurance plans.

<sup>a</sup> Breaux/Thomas proposal to the National Bipartisan Commission on the Future of Medicare (1999). This plan is similar to that proposed by Butler and Moffitt (1995). The Progressive Policy Institute (Sheils, Claxton and Haight, 1996) also has proposed a voucher benefit equal to the average HMO bid in each area for a standard Medicare benefit; capitated plans could offer additional benefits (as under current law), and enrollees who chose to remain in the Medicare fee-for-service (FFS) program would pay out-of-pocket any difference between the average FFS program cost and the voucher amount. Except for the voucher benefit, Aaron and Reschauer (1995) also have proposed a similar plan; their proposal would limit benefits to two standard designs and would use a variant of Medicare's current method of setting capitation rates for Medicare risk contracts.

<sup>b</sup> Gramm, Reitenmaier and Saving (1998).

<sup>c</sup> Feldstein (1999).

<sup>d</sup> Ferrara (1998).

assuming that cost of future benefits would be lower (due to competition in an individualized system of benefits) and that earnings on contributions would be higher (due to higher yields to investment in private equities), they conclude that new workers could fund their own benefits in full with much lower lifetime contributions relative to earnings than they could in the current program.

To the extent that these proposals project that the rate of contributions necessary to fund most workers' own future benefits would be less than in the present system, a significant share of younger workers' contributions (paid at today's statutory rate) could continue to finance benefits for current retirees and workers near retirement. Older workers (approximately age 45 or older) would continue to participate in Medicare on a largely pay-as-you-go basis. For example, the Gramm *et al.* proposal would fund benefits for current retirees and older workers simply by maintaining all workers' contributions at the current rate longer than would be necessary to fund each worker-cohort's own benefits. However, a competing proposal (Feldstein, 1999) assumes that future benefits could be funded only if revenues were increased or benefits were reduced.

**Revenue pooling.** In a simple individualized system funded by a flat tax on payroll, workers with low lifetime earnings would predictably accumulate lower retirement health assets than workers with higher lifetime earnings. This distribution of asset accumulation probably would correlate closely with levels of retirement income, so that poor elderly would have the least assets from which to finance health care in retirement.

To address this problem, each of the major proposals to individualize Medicare financing would redistribute contributions annually. For example, Gramm *et al.* propose pooling annual contributions within 10-year age cohorts and dividing it equally to deposit in each cohort member's personal account. (This would create a system in which each worker's payroll taxes would vary with the health care cost prospects of his or her cohort.) Feldstein proposes pooling and redistributing annual contributions among all workers to produce an equal annual amount of new saving in each worker's individual retiree health account. In contrast, some proposals to individualize Social Security financing would redistribute assets not at the

point of contribution, but instead at the point of retirement.

**Asset management.** Individual control and management of personal Medicare accounts are at the heart of proposals to individualize Medicare financing. All of these proposals imagine that workers would hold personal retirement health accounts and earn the greater rate of return available to assets when held in corporate stocks and bonds. This system, entailing dollar-by-dollar accounting for hundreds of millions of individual lifetime accounts, would present a much greater administrative challenge than the current system of credit accounting – which for Medicare requires only annual accounting for contributions and final verification of insured status. This issue of administrative feasibility aside, workers' retirement health assets might be managed with more or less federal oversight and management. For example, the system might be constructed as:

- *Individual private accounts managed exclusively by the individual.* Each worker (and his or her employer) would place contributions into the worker's personal retirement health account. (Alternatively, if contributions are pooled, the pooling agency could place contributions into the worker's personal account.) The worker would make all investment decisions and also bear the risk of financial losses. In this system, some workers might be unable to accumulate enough savings to buy a health insurance plan throughout their retirement, and the Medicaid program (or a new federal guarantee program, as Ferrara proposes) could bear much of the down-side risk of individual investment decisions.
- *Individual private accounts with federal oversight of investment options.* Again, workers and their employers (or a pooling agency) would place contributions into workers' individual retirement health accounts. However, the federal government would authorize qualified investment options to limit both individual risk-taking and allowable administrative fees. This system also would produce winners and losers, but it could limit the extent of both gains and losses. The Medicaid program (or a new federal guarantee program) would still be at risk for retirees who failed to achieve an adequate rate of return on lifetime contributions.



■ *A combination of a central public account and individual private accounts.* Workers would contribute some percentage of their payroll tax to a personal retirement health account, but the government would retain some (and possibly most) of Medicare payroll tax revenues in a central trust fund. At retirement, distributions from the central fund could take the form of an annual voucher to purchase health insurance. Retirees would supplement the voucher from their individual accounts to purchase a health plan and retain any balance in their personal account to finance uninsured medical expenses. The government might (as in some proposals to reform Social Security financing) invest some portion of Medicare assets in the private market to improve earnings on trust fund assets. This system would retain Medicare's current ability to equalize risk-taking and to minimize administrative cost. However, Medicare's investment managers would control a huge volume of assets and would need to take particular care not to distort capital markets, assuming that they also could avoid having their investment decisions politicized.

**Equity and adequacy at retirement.** Even when workers' annual contributions to an individual retirement health account are made equal, individual investment decisions may produce differences in earnings and, therefore, differences in individual workers' final asset accumulation. Differences in earnings might be random, or they might be related systematically (and inversely) to retirees' lifetime income and to their current personal income. To the extent that government limits workers' investment options (limiting both risk and administrative charges), differences in asset accumulation are likely to be smaller.

Obviously, retirees' ability to buy benefits could be assured by redistributing retirement health account assets at the time of retirement. While none of the major proposals to individualize Medicare would redistribute assets at retirement, some proposals for individualizing Social Security benefits would, and these might be useful in considering options for individualizing Medicare financing. For example, one proposal (Feldstein, 1997) would authorize a 5-percent tax on individual Social Security accounts at retirement to finance asset transfers to retirees whose personal Social Security accounts would provide less than 50 percent of the median annuity. Another analysis (Feldstein and Rangelova, 1998) suggests

that retirees might be indemnified against low lifetime accumulation (relative to the median) by taxing future workers, and that such a tax would impose a very small risk on future taxpayers. Such systems would ensure that every retiree started with at least a baseline asset (although the baseline could move with the median), and they would still be rewarded for having made successful investment decisions during their working years.

While it is relatively simple to imagine how to equalize assets at a point in time, stabilizing assets over time may be more difficult. None of the proposals to individualize either Medicare or Social Security financing yet has addressed the question of how to ensure benefit adequacy in a prolonged period of market downturn, even one of several years' duration. Prudent investors might place all of their assets in U.S. Treasury securities or cash as they near retirement, but less sophisticated investors might not, and they could be caught in a market downturn just at the time they would retire.

The proposal offered by Gramm *et al.*, which would fund future health insurance benefits within 10-year cohorts, may be particularly susceptible to cyclical market downturns that are timed to workers' retirement. If the market fell as the leading edge of the cohort began to retire and remained depressed for several years, the contributions required of other cohort members to fund their own benefits could rise dramatically, since the cohort's retirement health benefits are payable in the very near term and the cohort would have little time to recover lost assets. Alternatively, a cohort comprised of only older workers might prudently be holding their retirement health assets in very low-risk investments, but very conservative investment behavior also would reduce rates of return on investment and, therefore, retirees' ability ultimately to finance health benefits. The likelihood that low investment yields would be autocorrelated (McCurdy and Shoven, 1999) suggests that cohorts nearing retirement would bear significant risk.

Even if their rates of return on investment remained stable, required contributions could rise very steeply if health care costs happened to accelerate as workers neared retirement. Again, this problem would be worse in a system of cohort-financing for the reasons identified above – workers near retirement or in a cohort already partly retired would have a short time

and a small base of workers from which to finance the cost increase, and they could be disadvantaged further by holding their assets in conservative, low-yield investments.

**Net earnings on investment in an individualized system.** In all the proposals to individualize Medicare financing, higher yields on investment ultimately determine the adequacy of benefits, especially if other aspects of reform were to fail to stall the growth of health care costs. Gramm *et al.* assume modest real rates of return on individual investment – 3 to 4 percent (well below the 6 to 7 percent real rate of return earned on the Standard and Poor’s market index over the last 70 years), and about equal to the 5.5 percent money rate of return that Feldstein (1999) assumes. However, Geanakoplos *et al.* (1998) have argued that the greater investment earnings that might occur with individualized financing would result only from the prefunding of benefits (that is, from the accumulation of a larger asset base), not from higher rates of return, if those rates are properly measured to account for greater risk.

In any case, forecasting future rates of return with certainty is very difficult, and these proposals raise a number of macroeconomic and administrative issues that would make forecasting more difficult still. For example, the increase in the capital stock associated with full funding of future benefits would be substantial, and it could drive down historic real rates of return – by one estimate, about 2 percentage points (Feldstein, 1997). The administrative costs of operating a system of individual accounts could reduce the real rate of return on individual investments by another full percentage point or more (Mitchell, 1996; Poterba *et al.*, 1997).

Finally, differences in the effective rates of return achieved by individual workers in such a system are inevitable. These differences pose problems even if the failure to earn the average rate of return on investment is random among individuals, but they pose still greater problems if low-income workers are more likely to make low average rates of return than are high-income workers. Taxing and redistributing assets at retirement to achieve an adequate baseline asset might resolve at least some of this problem. However, to the extent that inequality and adequacy remain problems in a system of individualized Medicare financing, the Medicaid program, and per-

haps other government programs as well, would remain at risk.

## Individualized benefits

Proposals to individualize Medicare generally envision enrollee choice across a full range of competing private plans – including those now available in the market to the nonelderly population, as well as the options authorized for sale to Medicare beneficiaries under Medicare+Choice. They would remove limits to enrollment in medical saving account (MSA) plans, and they may also envision changes to current law that would bolster the availability of fee-for-service options. For example, Ferrara (1998) would allow beneficiaries to pay providers more than Medicare’s fee levels, without providers incurring a penalty.

Whether more extensive choice of plans within the Medicare program is feasible depends on Medicare’s ability to maintain a stable portfolio of products available to all Medicare beneficiaries, and also a portfolio of products with stable prices and benefits. Medicare’s ability to do this may rest in part on whether its forthcoming system of risk adjustments for health insurance plans is successful. However, even in a risk-adjusted system, price differences among plans are likely to emerge, and unexpected price increases are likely to occur. Different insurers in the same market may price even the same minimum benefit design differently, sometimes to attract or deter applicants with different risk and cost profiles. Thus, Federal regulation of private Medicare insurance plans could be necessary beyond the guaranteed issue that Medicare now requires of private risk contractors. One might imagine a number of Federal regulations that could be necessary to stabilize this market – including price constraints (or “rate bands”) to contain the price differentials that insurers normally would charge older or sicker applicants, minimum loss ratios to enforce price competition, and standardization of products.

Even with this type of new Federal regulation, beneficiaries would need detailed information about benefit and price differences that is not now readily available to them. They also may need an active public ombudsman program to help them choose among plans. Various recent studies suggest that many older and frail beneficiaries may be unable to navigate this market themselves and may have insufficient family support to navigate for them.

Price differences certainly also would emerge across markets in ways that are unlikely to correlate with differences in rates of return to investment. If there were no parallel system of geographic subsidies (for example, financed from general revenues), workers' contribution rates would need to vary geographically, or a system of asset redistribution at retirement would have to compensate not only for differences in workers' lifetime contributions but also for geographic differences in health care costs to ensure that all retirees would have equal ability to buy even basic coverage. Even if only benefits (not financing) were individualized – as in “premium support” proposals – geographic differences in health care costs pose a major problem in calculating the subsidy that an individual beneficiary should receive.

Finally, if workers failed to anticipate future health care cost increases correctly, they might find that their asset at retirement is inadequate to buy even basic health insurance throughout their remaining lifetimes. Proposals to individualize financing and benefits generally assume that competition among health plans will be more successful in constraining health care costs than experience has indicated. In any case, all of the proposals transfer the risk of unexpected health care cost increases after retirement from current workers to current beneficiaries. If multi-year insurance contracts were available, retirees could spread the risk of rising health care costs across a number of years, but insurers have rarely offered multi-year health insurance contracts even to large-group buyers (that is, large employers); and even then these contracts may span only two or three years with “escape clauses” should health care costs escalate unexpectedly. Private insurers have shown no interest in writing these contracts to individuals or in writing contracts that cover longer periods of time.

## Summary

Proposals to individualize Medicare financing raise many questions about how such a system would ensure equitable and adequate financing for future generations. To the extent that future retirees may be unable to afford comprehensive health insurance

throughout their remaining lives, these proposals also raise questions about the ultimate cost to the federal government and to state and local governments to support a larger Medicaid program or to devise subsidies to supplement retirees' health account balances.

It is unclear whether the ultimate rate of return on individually invested contributions – accounting for the macroeconomic effects of an individualized and fully funded system, greater administrative costs, and greater risk – would be sufficient to justify such a major reform of Medicare financing. Moreover, the administrative feasibility of individualizing a universal social insurance program has been questioned. Medicare's current system for determining eligibility is much simpler administratively than a system that must account for every dollar of contributions and also redistribute contributions and/or asset accumulation to ensure that every retiree has at least a minimum account balance from which to buy health insurance.

Even when existing proposals to individualize Medicare financing and benefits are supplemented with concepts from the ranks of similar Social Security proposals, an impressive number of questions about how a reformed system would work are yet unanswered. For example, how would retirees bear the burden of poor investment choices and market-wide downturns? What are the implications for Medicaid? How great are other potential public-sector costs if workers do not accumulate enough assets to finance their health care? What is the true cost-containment potential of Medicare benefit redesign? What rates of return could an individualized system of financing ultimately achieve? And what legal and institutional changes would become necessary to govern both investment markets and health insurance markets? The challenge of resolving any one of these issues would not necessarily condemn the idea of an individualized system. However, in combination they suggest the difficulty of designing reforms that would substantially change both Medicare's financing and its benefits to improve solvency, and still maintain the benefit security for retirees that is a cornerstone of the program.



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