



## **AFTER THE BIPARTISAN COMMISSION: WHAT NEXT FOR MEDICARE?**

**Summary of Panel Discussion  
New York University, Robert F. Wagner Graduate School of Public Service**

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This paper is based on the third of four symposia sponsored by The Commonwealth Fund and the Robert F. Wagner Graduate School of Public Service at New York University. These sessions provide a forum for policymakers, researchers, and practitioners to explore current issues in health policy. Panelists at this event were Stuart H. Altman, Sol C. Chaikin Professor of National Health Policy at the Florence Heller Graduate School for Social Policy, Brandeis University; Karen Davis, President of the Commonwealth Fund; and Charles N. “Chip” Kahn III, President of the Health Insurance Association of America. The program was introduced by Jan Blustein, M.D., Assistant Professor of Health Policy and Management at the Wagner School, and moderated by Jo Ivey Boufford, M.D., the school’s dean. Katherine E. Garrett wrote this briefing paper.

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## AFTER THE BIPARTISAN COMMISSION: WHAT NEXT FOR MEDICARE?

Medicare has played a crucial role in assuring health and economic security for elderly and disabled Americans over the last three and a half decades. When it was established in 1965 as a social insurance program, nearly half the nation's elderly people and about 70 percent of individuals with chronic disease were uninsured. Medicare, coupled with Social Security income support, has alleviated poverty among elderly Americans and contributed to significant improvements in health status.

Medicare, however, faces an uncertain future. The National Bipartisan Commission on the Future of Medicare, established by the Balanced Budget Act of 1997 (BBA), was charged with examining the Medicare program and making recommendations to strengthen and improve it, especially in light of the steep increase in retiring baby boomers expected by 2010. The commission's 17 members were appointed by President Clinton and by Republican and Democratic congressional leaders. Senator John Breaux (D-La.) served as chairman of the commission, while Representative Bill Thomas (R-Ca.) was the administrative chairman.

The commission was required by law to complete its report by March 1, 1999. By that time, however, the urgency for sweeping Medicare reform had been mitigated by the greater-than-expected effectiveness of BBA cuts in reducing the cost of Medicare, as well as by the strong U.S. economy. Medicare Part A—the hospital-related part of the program that is funded by payroll taxes—is now expected to remain solvent until 2015.

**The National Bipartisan Commission on the Future of Medicare: A "Round"**  
Without the catalyzing effect of an immediate crisis, the commission members' already significant differences on how to reconfigure the Medicare program grew even more prominent. One former member likened sitting on the commission to being in the middle of a musical round: although the song is sung in unison, each participant is repeating his part of the song over and over again without listening to the words of the other singers.

The commission eventually split into three groups—"financialists," "benefitists," and "structuralists"—each with its own view about which aspect of the Medicare program needed the most attention:

- Financialists felt that the commission's focus should be on the Medicare program's projected insolvency. Conservative financialists saw these financial pressures as requiring major changes in Medicare, since raising taxes was, to them, an unacceptable option. Liberal financialists, while agreeing that the outlook for the current program was bleak, relied heavily on dedicating a portion of the federal budget surplus or increasing payroll taxes in formulating their solutions.
- Benefitists focused on the coverage offered by Medicare. For the liberal benefitists, the key issue was the program's coverage of only 53 percent of dollars spent on health care by senior citizens. Conservative benefitists, however, held that even the current level of benefits was unsustainable and sought politically viable ways to reduce it.
- Structuralists sought fundamental change in Medicare, which they saw as too large, bureaucratic, and cumbersome. They believed that the program could be improved by expanding the role of health maintenance organizations (HMOs) and relying on the market as the primary driver of efficiency and cost-containment.

Ultimately, the concerns of the structuralists moved to the fore of the commission's agenda. The major component of Chairman Breaux's proposal was the creation of a premium support system modeled on the Federal Employees Health Benefits Program (FEHBP). Under this system, Medicare beneficiaries would be allowed to select health insurance coverage from a menu of private managed care plans or opt for the traditional fee-for-service plan. Managed care organizations would offer "standard option" as well as "high option" plans; for most seniors, premium support would be set at about 88 percent of the standard plan—a cost ultimately determined by the market. Those beneficiaries willing to incur the extra cost could alternatively purchase an expanded benefit package. The structuralists also recommended unifying Medicare's Part A and Part B deductible structures.

Chairman Breaux's proposal also dealt to some extent with the concerns of the financialists and benefitists. From a fiscal perspective, the assumption was made that increased competition and efficiency would result in cost savings for Medicare. For the benefitists, the proposal included prescription drug coverage for low-income beneficiaries and support for improved access to private prescription drug coverage for other beneficiaries. How benefits should be extended would again be determined by the marketplace.

In the end, the chairman's proposal received only 10 of the 11-vote supermajority it needed to be referred to Congress and the President, and the recommendations were never formally adopted by the commission. Philosophical disagreements, together with political pressures, had impeded the adoption of a workable plan. For some members, the second-best option to their preferred approach was to choose to do nothing.

The commission thus became the first in recent Washington memory to conclude its work without issuing a final report—even one without formal recommendations—that could be used to inform ongoing policy discussion. This lack of documentation of the commission's work was a disappointment to many members, as well as to others involved in evaluating and shaping health policy.

### Perspectives on the Commission's Proposed Recommendations

Many observers of the commission found much to question about the viability of the structuralist approach to Medicare reform. For some, the shift to premium support—in effect, transforming Medicare into a government subsidy rather than a program providing the same benefits to all entitled—was a more radical alteration of a fundamentally sound program than the situation required. Most projections of Medicare's future financial status are inherently unreliable, given the uncertainty of economic trends, possible breakthroughs in treatments for medical conditions common to Medicare beneficiaries, increased efficiencies in the health care industry, and healthier lifestyles of those who will be enrolled in Medicare in 2015. Incremental, rather than radical, changes to Medicare would therefore make more sense to pursue. Under some scenarios, even full adoption of the premium support structure would result in little change in the percentage of the gross domestic product devoted to Medicare—4.45 percent under premium support versus 4.62 percent under the current program.<sup>1</sup> Structural change would seem to have little impact on overall costs.

Assumptions about the effectiveness of Chairman Breaux's premium support plan also do not take into account the differences between Medicare and the FEHBP on which premium support was modeled. At present, Medicare beneficiaries who participate in Medicare+Choice, the program's managed care option, may opt out with one month's notice.

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<sup>1</sup> Marilyn Moon, *Restructuring Medicare: Impacts on Beneficiaries*, The Commonwealth Fund, May 1999.

Most employer-sponsored programs, including the FEHBP, require a year's commitment to a selected plan. Yet even with this more flexible policy, roughly 85 percent of Medicare beneficiaries choose the fee-for-service option over Medicare+Choice. Many observers question whether the managed care-like choices offered in a premium support plan really hold much appeal.

Indeed, many doubt whether a managed care option can work at all with a population of elderly and disabled enrollees. Under Medicare+Choice, sicker people have tended to stay in traditional Medicare, while healthier beneficiaries have opted for managed care plans. If this trend continues, the cost of traditional Medicare could spiral out of control.

### The President's Proposal for Medicare

The commission's failure to produce recommendations compelled President Clinton to introduce his own Medicare reform proposal in June 1999. The President's plan rejects converting Medicare into a fixed financial subsidy and preserves the program as a universal entitlement. While the Clinton proposal does contain a structural component that increases the ability of HMOs serving Medicare members to compete on the basis of price, the government—not the market—would set the base rate. Expected savings from this change would total \$8 billion over 10 years.

Under the Clinton plan's generally benefitist approach, Medicare would cover prescription drugs and existing copayments and deductibles for preventive care services would be eliminated. The plan addresses financialists' concerns about the drug benefit's expected costs and other fiscal pressures by targeting almost \$800 billion from projected federal government surpluses for Medicare, instituting a new copayment for laboratory services, linking the deductible for physician and other outpatient services to the consumer price index, and extending moderated versions of Medicare cuts included in the BBA beyond 2002. In addition, the public cost of a drug benefit would be partially offset by premium contributions and 50 percent copayments by beneficiaries.

### Prospects for Medicare Beyond 2000

For the time being, Medicare reform has lost some of its urgency. As a result, the participants in the Medicare reform round continue to sing their parts without any one voice seeking harmony with another. President Clinton's current proposal represents one part of the round of varying, sometimes overlapping, but rarely concurring views on the future of Medicare.

Nevertheless, Medicare reform will remain a pressing concern for the public, health care providers, and policymakers. Greater-than-anticipated cost savings from the BBA could lead to legislative relief from those cuts, and the projected insolvency date for the Part A trust fund—2015—could creep closer to 2010. On the other hand, insolvency could be further delayed to 2027 if a substantial portion of the current federal budget surplus is earmarked for Medicare.

Following the 2000 elections, the opportunity exists for renewed attention to Medicare reform. The program's uncertain outlook, plus the realization that a large percentage of the population will soon become eligible for Medicare, may be the stimulus for a new national consensus. Others note that rising premiums for all types of insurance may place overall health care reform back on the national policy agenda as a major domestic priority.

The wisdom of an incremental approach to change in the Medicare program remains to be seen. Uncertainty on many levels seems to point to a go-slow approach—one that relies not on dubious long-term expense projections but on cautious adjustments made every three to five years. At the same time, an incremental approach contains some risks. First, the consensus for change may arrive too late to forestall the need for more drastic solutions. Second, the impetus for a consensus on change may be a severe economic recession.

Preserving and strengthening Medicare for future generations will require more than simple solutions. Public opinion surveys indicate that most Americans favor expanding Medicare but oppose nearly all options for bringing its revenues and expenditures into balance. Absent any broad consensus, Medicare may continue to be just solvent enough. Consequently, assuring the future health and economic security for older and disabled Americans is likely to remain an enduring challenge.