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ISSUE BRIEF

THE FUTURE OF MEDICARE

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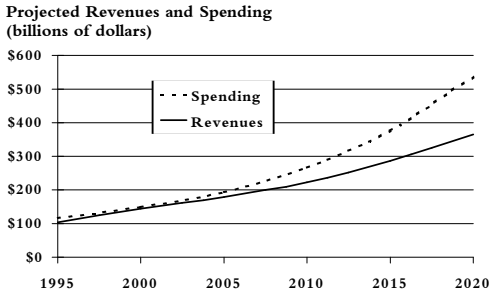
The United States faces a considerable challenge in providing health care for its elderly and disabled residents in the coming years. For one, the looming retirement of the baby boom generation will substantially increase the number of Medicare beneficiaries.[1] The percentage of the population covered by Medicare could increase from about 14 percent today to 22 percent in the year 2025.

In addition, the Medicare Hospital Insurance (Part A) Trust Fund, as currently structured, is projected to be exhausted after 2008. This fund is financed primarily through payroll taxes and pays for hospital and other institutional care. Experts predict that by 2020, without changes to the program, spending will exceed revenues by $200 billion.

Projected Shortfall for Medicare Hospital Insurance Trust Fund



Source: Health Care Financing Administration, Office of the Actuary, 1998.

The National Bipartisan Commission on the Future of Medicare, created by the Balanced Budget Act (BBA) of 1997, is charged with examining the Medicare program and making recommendations on financing health care for the elderly and disabled in the twenty-first century. The 17-member commission is scheduled to complete its report by March 1, 1999. It is approaching its task through two primary routes: developing incremental reforms to the Medicare program and analyzing major restructuring of the program. Incremental reforms would maintain the current program with some important changes, while restructuring would transform the program to one of fixed payments to private insurance and managed care plans. In addition, the commission is reviewing projections of the future costs of care and sources of revenues to finance care for the elderly and disabled.

INCREMENTAL REFORMS

An incremental approach to reforming the Medicare program would continue the practice of the past decade of adopting a set of changes to the program every three to five years, rather than overhauling the program at a single point in time.[2] This ongoing approach would permit multiple changes to the program to reflect the constantly evolving health and financial status of the elderly, the costs of Medicare benefits, the national health care system, and the federal budget.

Under this approach, a package of revisions to Medicare would be adopted in the near future, perhaps in 2001, with additional changes considered in intervals thereafter. Current options under consideration include slowing increases in payments to

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providers, reducing benefits to selected beneficiaries, and improving protections for the elderly, especially those with low incomes.

Slowing Increases in Payments to Providers

The BBA is expected to lower the growth in annual per capita Medicare costs to less than 5.5 percent through the year 2007. The act made a significant downpayment on Medicare's future by achieving $116 billion in savings from 1998 to 2002 and $394 billion over the 10-year period from 1998 to 2007. It also extended the projected insolvency of the Medicare Hospital Insurance Trust Fund from the year 2001 to 2008, and cut the projected deficit in half over 75 years. Approximately three-fourths of the 10-year savings are to come from tightening prospective payment rates to health care providers and to managed care plans.[3]

Following in the path of the BBA, future legislation could continue to limit incrementally the growth of Medicare payments to hospitals, physicians and other health care providers, and managed care plans. Slowing Medicare expenditures in this way could reduce the need to impose higher costs on beneficiaries or to cut benefits or raise taxes. On the other hand, it could create financial instability in the health care industry and limit beneficiaries' access to new medical technologies or providers.

A key feature of the BBA was the institution of interim payment limits on home health services, skilled nursing facilities, and rehabilitation hospitals, to be followed by new prospective payment systems. Home health providers have argued that savings are excessive and that a serious shortcoming of the new interim payment system is that it reflects historical average spending per beneficiary—not the actual care needs of an agency's patients. Analysis by Barbara Gage of the Urban Institute illustrated the wide variation in costs of home health services in 1995 for patients with different medical conditions, ranging from $1,588 per episode for joint-disorder patients to $4,601 for patients with kidney ailments.[4] The interim payment limit system could lead to access problems for high-cost home health users. Congress recently acted to provide some temporary relief to home health agencies, but appropriate long-term solutions may be more elusive.

It is too soon to tell if the BBA payment changes were too stringent or can be further tightened in 2002 when the current provisions expire. Managed care plans have pulled out of some geographic areas and are certain to resist holding the annual rate of increase in payments to 2 percent per year—the rate projected under the BBA. Hospitals, home health agencies, and skilled nursing facilities have also expressed concern that limiting payments may threaten care. An ongoing assessment will be necessary to measure the potential for savings, with the goal of assuring that Medicare payment rates do not depart substantially from private market rates. Even if further savings are generated by tightening payments, this measure alone may not be adequate to sustain the program in the long run. Consideration of benefit reductions or new revenue options may be necessary as well.

Reducing Benefits or Increasing Premiums for Selected Elderly People

Other proposed incremental options to cut the rate of growth in Medicare costs include raising the age of eligibility and tying premium rates to income levels. Under the first option, proposals have been made to increase the age

of eligibility to 67. While boosting the age requirement would reduce the number of people covered under the program and cut costs, many older people may have difficulty working to age 67 or may not have jobs with health benefits. More than 500,000 people ages 65 and 66 would be left without health insurance, and more would be unable to afford private health insurance coverage with benefits similar to those of Medicare. In addition, analysis indicates that the impact of such a change on program costs and trust fund solvency would be small.[5]

A second proposal would raise premiums on a sliding scale for Part B of Medicare, which covers physician, outpatient hospital, laboratory, and other services. Premiums are currently the same for all beneficiaries, covering 25 percent of Part B benefits. Under this proposal, single beneficiaries with incomes less than $50,000 and couples with incomes less than $75,000 would pay no additional premiums for Medicare Part B, while single individuals with incomes above $100,000 and couples with incomes above $125,000 would pay 100 percent of Part B costs.

The Congressional Budget Office, however, has indicated that savings from this proposal would be about $3.9 billion over five years, only about 0.3 percent of the total cost of Medicare. The small savings reflect the fact that only 3 percent of single individuals have incomes sufficient to qualify for higher Part B premiums, and only 0.6 percent have incomes sufficient to qualify for the full premium.[6] The share of married beneficiaries who meet the income threshold would be 9 percent, and only 2.9 percent would have incomes high enough to qualify for full Part B premium. Analysts have also described the cumbersome administrative system necessary to track and report the incomes of the almost 40 million elderly and disabled people.

Improving Protections for Elderly Beneficiaries

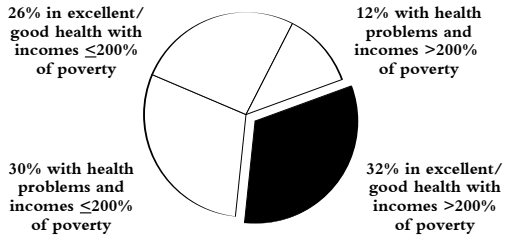
If Medicare is to be modernized to assure that it continues to provide health and economic security for elderly and disabled beneficiaries, consideration should be given to improving coverage, at least for high-risk beneficiaries. Medicare beneficiaries already shoulder high health care costs: in 1996, they each spent on average $2,605, or 21 percent of their incomes, on premiums, cost sharing, and noncovered services.[7] This figure compares with 8 percent of the incomes of the population under age 65. In total, Medicare now pays only 53 percent of the health care costs of the elderly.

The BBA included a major increase in the premium for Medicare Part B, which is financed by a combination of beneficiary premiums and general revenues. The annual premium is now projected to be $1,060 in the year 2006, compared with $526 today.[8]

Such an increase would be especially burdensome for low-income and disabled beneficiaries. Nearly two-thirds of the elderly have incomes less than $25,000,[9] and those living below 125 percent of poverty spend more than 30 percent of their incomes on out-of-pocket health care costs.[10] More than 40 percent of the elderly report significant health problems, and more than half of the poor and near-poor elderly report being in fair or poor health.[11]

Profile of Medicare Beneficiaries, by Poverty Level and Health

Two of Three Have Health Problems* or Live on Low Incomes



*In fair or poor health or disabled

Source: Kaiser/Commonwealth 1997 *Survey of Medicare Beneficiaries*, Louis Harris and Associates, Inc., 1997.

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The Medicaid program has three types of assistance to protect low-income Medicare beneficiaries. The first is the Qualified Medicare Beneficiary (QMB) program, which covers premiums, deductibles, and cost sharing for those with incomes at or below 100 percent of the federal poverty level. The Specified Low-Income Medicare Beneficiary (SLMB) program extends protections for premiums further up the income scale to 120 percent of poverty. The BBA added a Qualifying Individuals (QI) program, allocating $1.5 billion to states to extend premium protections for those with incomes up to 135 percent of poverty, and partial premium protections for those with incomes up to 175 percent of poverty. However, funding is adequate to cover less than one-quarter of those eligible, and the QI program expires in 2002.

Many eligible low-income elderly do not participate in the QMB and SLMB programs—only 78 percent and 16 percent respectively.[12] Nonparticipants remain either unaware of the program or unwilling to participate because of complex enrollment processes, requirements to apply at welfare offices, and sizeable time lags in activating eligibility.

Options to extend coverage for premiums, out-of-pocket costs, and additional benefits for low-income Medicare beneficiaries include shifting coverage for premiums and out-of-pocket costs for the low-income elderly from Medicaid to Medicare. This approach would likely provide financial protections to more low-income beneficiaries but would increase costs. As many as 6 million people would be served by these protections, up from about 4.8 million at present, at new net costs of about $1.4 billion per year.

Medicare benefits might also be expanded to include prescription drugs. More than three-quarters of the elderly take prescriptions drugs on a regular basis, and 11 percent spend more than $100 per month for these drugs.[13] The chronically ill, older, and low-income elderly are especially dependent upon these medicines.

Managed care plans have attracted enrollees in the past by offering prescription drug benefits, often without charging additional premiums. However, as Medicare has begun to tighten payments to plans, these benefits are being reduced or dropped, exposing beneficiaries to substantial unplanned costs. Pressure may grow to cover prescription drugs to offset cutbacks by managed care plans.

RESTRUCTURING THE MEDICARE PROGRAM

An alternative strategy to incremental change is converting the Medicare program to a private health insurance coverage system. The BBA included the institution of Medicare+Choice, a program that introduces a variety of changes: it expands the array of private plans offered to beneficiaries, provides for an annual open enrollment to inform beneficiaries of private plan options, calls for a new risk-adjusted payment method for private plans to be developed and implemented by the year 2002, and sets quality standards for private plans.

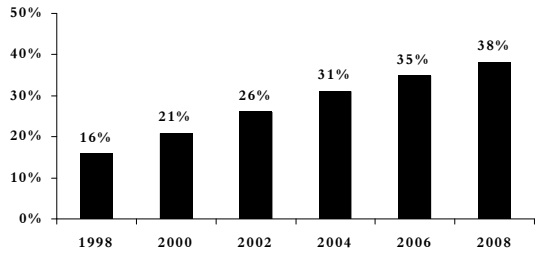
The Bipartisan Commission may decide to build on Medicare+Choice, recommending the replacement of the traditional Medicare fee-for-service program with one that requires all beneficiaries to enroll in private plans. Unlike the current program, such an alternative would not set private plan premiums as payment in full for a defined set of Medicare benefits, but would provide beneficiaries with a fixed dollar amount, alternatively called a defined contribution or a premium support. Competition and choice

among plans would be expected to hold down premiums, but if the defined premium contribution did not cover private plan premiums, beneficiaries could face greater costs over time. The feasibility of such a course will depend in part on successful implementation of the Medicare+Choice program.

Medicare+Choice Managed Care Program

Medicare+Choice represents the most important current change in the Medicare program. Under this strategy, the number of beneficiaries in managed care is projected to increase from 6 million today to more than 16 million by 2008. Medicare+Choice will carry out a structured open enrollment period in November of each year, beginning in 1999, and five states will pilot test open enrollment in the fall of 1998. A new risk adjustment system is scheduled to be initiated in the year 2000.

Projected Medicare Managed Care Plan Enrollment, 1998-2008



Source: Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1999-2008*, January 1998.

Medicare+Choice poses three major issues: 1) whether beneficiaries will be able to make informed choices and avoid low-quality plans, 2) whether new payment methods will prevent managed care plans from benefiting by enrolling primarily healthier patients, and 3) whether managed care will save Medicare money. The availability of information on the quality of plans is improving[14] but can be difficult to understand, and even the best available risk adjustment method still provides substantial incentives for plans to avoid enrolling the chronically ill and frail elderly.

The BBA limited Medicare payment increases to managed care plans to 2 percent per year until 2002 in most geographic areas, which should reduce overpayments to plans. However, the initial response to Medicare+Choice has fallen short of expectations. Few new private plans have opted to participate, and HMOs are pulling out of Medicare in counties where payment rates are less favorable than other areas. Nor is there any evidence to date of Medicare savings from this strategy.

Defined Premium Contributions

Under this approach, the federal commitment and expenditures would be set at a defined dollar amount per individual beneficiary and increased by a fixed percentage each year. Medicare would be replaced with a system whereby the elderly and disabled could choose from an array of private health insurance and managed care plans, but Medicare's payments would not be guaranteed to cover the cost of benefits. While this approach would make federal expenditures more predictable, the health insurance benefits and out-of-pocket costs of the elderly and disabled beneficiaries would be less certain.

A key element of the policy would be a fixed rate of increase in the premium contribution from year to year. The contribution could be indexed over time to match the growth of the economy, the federal budget, or private health insurance premiums. Historically, private health insurance and total health expenditures have grown 3 percentage points faster than the gross domestic product (GDP).

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If the Medicare premium contribution is indexed to the overall economy or to the growth in current projected Medicare tax revenues, it is unlikely to rise as quickly as medical costs, and the elderly would face higher out-of-pocket costs and premiums over time. If the defined premium rate grew at the same pace as projected Medicare revenues, for example, instead of the Medicare Hospital Insurance Trust Fund having a shortfall of $200 billion in the year 2020, the trust fund fiscal problem would be solved. Medicare beneficiaries would be responsible for an additional $200 billion of their own Part A health care expenses now covered by Medicare. In addition to paying a Part B premium that will increase substantially under current law, beneficiaries would also be responsible for the gap between the defined premium contribution and projected Medicare costs.

Such an approach could shift costs to beneficiaries at a rate that would effectively double or triple the amount they are required to pay each year for Medicare benefits. The added burdens could total as much as 15 to 20 percent of a typical beneficiary's income, in addition to out-of-pocket costs that already average 21 percent of income.

This approach would also require a sophisticated method of relating the level of Medicare's defined premium contribution to the health status of beneficiaries. While a risk adjustment system is being designed, questions have already been raised regarding its adequacy and effect on Medicare's ability to pool risk. Inadequately adjusted rates could jeopardize coverage for the chronically ill and older elderly and contribute to financial instability among plans. Those plans unfortunate enough to enroll sicker beneficiaries could face what is known in the insurance industry as a "death spiral": premiums could rise, causing healthier patients to disenroll, which would result in an even sicker and more costly enrollee patient mix.

Under some defined premium contribution proposals, traditional fee-for-service Medicare would be retained as an option. Fee-for-service Medicare has lower administrative costs than managed care plans, and its prospective payment rates for hospitals and physicians are typically lower than those obtained by managed care plans. These economic advantages and familiarity with the program should make this an attractive option for beneficiaries. If, however, as is the present case, sicker beneficiaries select traditional Medicare while healthier beneficiaries join managed care plans, traditional Medicare could become more expensive to beneficiaries over time. This circumstance could be exacerbated if risk adjustment methods are inadequate to adjust for adverse risk selection. If substantial favorable risk selection occurs in managed care, or if beneficiaries are very premium-price sensitive, this option could eventually disappear.

REVENUES AND MEDICARE EXPENDITURES

None of the options before the Bipartisan Commission provides an easy solution to making the Medicare program financially viable. A recent Henry J. Kaiser Family Foundation/ Harvard University survey found that Americans oppose nearly all options to bring Medicare revenues and expenditures into balance and favor expanding Medicare. (See Table 1.) In the end some combination of strategies may be required, including the difficult option of increasing payroll taxes, which finance the Medicare Hospital Insurance Trust Fund. Medicare trustees estimate that an increase of one-third of one percentage point in payroll taxes for

employers and employees—from 1.45 percent of earnings to 1.81 percent of earnings—would save enough to balance the trust fund for 25 years.[15]

dictions difficult: the progress of biomedical research, the health habits of older people, the organization and operation of health care providers and payers, trends in the overall economy. Given these uncertainties, considering and adopting new Medicare policies every three to five years, as has been the recent practice, may be more practical than a single effort to resolve the major issues raised by the retirement of the baby boom generation. A more gradual incremental approach would also afford time to judge the effectiveness of the new Medicare+Choice program.

Table 1

Proposed Change	Public Opinion	
	Oppose (%)	Support (%)
Requiring seniors to pay a larger share of Medicare costs	84%	13%
Instituting a defined contribution approach that would limit Medicare contributions for an individual to a fixed annual amount	69%	26%
Increasing worker payroll taxes	64%	31%
Raising the age of eligibility to 67	63%	34%
Encouraging seniors in traditional Medicare to move to managed care	56%	38%
Reducing payments to doctors and hospitals for treating Medicare patients	48%	47%
Requiring higher-income seniors to pay more	32%	65%
Expanding Medicare to cover prescription drugs	26%	68%
Expanding Medicare to cover long-term care	26%	69%
Letting people ages 62 to 64 buy into the program	37%	60%

Source: Henry J. Kaiser Family Foundation/Harvard University School of Public Health National Survey on Medicare, October 20, 1998.

Note: Numbers do not add to 100 because some respondents had no opinion or did not know the answer.

Sharing the fiscal responsibility of health care for beneficiaries may require sacrifices by health care providers, beneficiaries, and taxpayers. A combination of reduced provider payments, increased managed care savings, benefit changes, greater beneficiary premiums, and tax increases may be required to balance competing concerns. To weigh the effect of various option packages will require reliable estimates of future Medicare revenues and expenditures.

Key to future projections is the expected growth in total health care spending over time. In 1996, health care spending was approximately 13.6 percent of GDP. If this percentage rises at the same rate as Medicare is projected to rise, experts predict the total would be more than 18 percent of GDP by 2025.[16] Many factors make long-term pre-

CONCLUSION

Following the adoption of the BBA a year ago, The Commonwealth Fund refocused the work of its Program on Medicare's Future to address the major issues in the long-run future of Medicare, together with the most significant issues in the implementation of Medicare+Choice

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and new prospective payment programs. Over the past year, Marilyn Moon, director of the Program on Medicare's Future, and other Fund grantees and staff have made important contributions to the analysis of the most urgent issues under consideration by the Bipartisan Commission and provided expert invited testimony. The challenge in the next year will be to continue to carry out timely, objective work regarding options under consideration. This work should help build consensus for reforms that assure that Medicare continues to provide health and economic security for older and disabled Americans in the twenty-first century.

NOTES

[1] Marilyn Moon, *Projections of Medicare Spending: A Prelude to Examining Options for the Future,* The Urban Institute, July 1998.

[2] Significant changes to the Medicare program, resulting in substantial savings, were adopted in 1997, 1993, 1990, 1989, and 1987.

[3] Marilyn Moon, Barbara Gage, and Alison Evans, *An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997,* The Commonwealth Fund, September 1997.

[4] Barbara Gage, *The Balanced Budget Act: Implications for Post-Acute Services,* The Urban Institute, September 1998.

[5] Timothy A. Waidmann, "Potential Effects of Raising Medicare's Eligibility Age," *Health Affairs* 17 (March/April 1998):156–164.

[6] Moon et al., September 1997.

[7] Marilyn Moon, *Restructuring Medicare's Cost Sharing,* The Commonwealth Fund, December 1996.

[8] Calculated from Table III.B1, p. 68, of the *1998 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund,* April 28, 1998.

[9] Cathy Schoen, Patricia Neuman, Diane Rowland, Karen Davis, Michelle Kitchman, and Drew Altman, *The Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries,* The Commonwealth Fund, November 1998.

[10] Moon, December 1996.

[11] Schoen et al., November 1998.

[12] Marilyn Moon, Niall Brennan, and Misha Segal, "Options for Aiding Low-Income Medicare Beneficiaries," *Inquiry* 35 (Fall 1998):346–356.

[13] Schoen et al., November 1998.

[14] With support from The Commonwealth Fund, *Consumer Reports* has rated more than 200 Medicare HMOs. See Trudy Lieberman, "Medicare: New Choices, New Worries," *Consumer Reports* 63 (September 1998):27–38.

[15] *1998 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund,* April 28, 1998, p. 16.

[16] Moon, July 1998.

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