Medicare

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Mr. Chairman and Members of the Committee, I appreciate this opportunity to discuss with you some of the budgetary issues raised by Medicare reform and efforts to provide prescription drug coverage to Medicare beneficiaries. The political climate, the policy environment, and the budget situation appear to be unusually favorable for addressing these problems. Moreover, during the past few years a considerable amount of new analysis has focused on various ways of dealing with the Medicare prescription drug problem and options for fundamental reform. This analysis should help to inform policymakers about the possible consequences of their decisions.

As he promised during the campaign, the President has put prescription drug coverage and Medicare reform high on his Administration's agenda. Reflecting this commitment, the second legislative initiative that the President sent to Congress was his plan to provide grants so that states could offer, for the next four years, prescription drug coverage to low-income Medicare beneficiaries and catastrophic protection for all beneficiaries. The President also has reiterated his interest in more fundamental Medicare reforms, pointing to the approach developed by the National Bipartisan Commission on the Future of Medicare as a useful starting point.

In Congress, there is broad bipartisan support for proposals that would give all Medicare beneficiaries access to some form of prescription drug coverage on a voluntary basis. But sharp disagreements remain over just how this objective should be accomplished. Nevertheless, a number of options have been developed. Several bills were introduced in the 106th Congress and one, H.R. 4680, was approved by the House.

Since 1998, considerable effort has gone into developing longer-term Medicare reform options. While the media and interest groups have focused on policy disagreements and the failure to move reform legislation forward, there has been a surprising amount of policy convergence recently. In many respects, the Clinton administration's *Plan to Modernize and Strengthen Medicare for the 21st Century,* which Senator Moynihan introduced as S. 2342 in the last Congress, and the *Medicare Prescription Drug and Modernization Act (S. 2807)*, a third-generation variant of the Bipartisan Commission's plan that Senators Breaux and Frist crafted last year, are close, if not kissing, cousins.

The Congressional Budget Office now projects that surpluses, excluding those of the Social Security and Medicare Hospital Insurance Trust Funds, will total $2,730 billion over the next ten years. For Medicare, this is welcome news both because it will be expensive to add prescription drug coverage to the Medicare benefit package and because fundamental Medicare reform is likely to cost, not save, money during a transition period. There are, of course, many competing claims on those budget surpluses. Therefore, those who would strengthen the Medicare program for the long run need to ensure that, as decisions are made on tax cuts and spending initiatives, sufficient resources are reserved to address Medicare's problems.

The remainder of my statement focuses on two issues: why it is necessary to reform or restructure Medicare and the likely budgetary impact of a Medicare prescription drug benefit.

Why Medicare Reform?

Before a thoughtful debate can begin about reforming or restructuring Medicare, policy makers must have a clear notion of the problems that reform is intended to address. One part is easy. The five main problems all begin with the letter "I"—insolvency, inadequacy, inefficiency, inequity, and incompatibility.

1. ***Insolvency***: The program, as currently structured, is *probably* unsustainable from a fiscal perspective. In the past, the program's fiscal problems have been manifested through the impending insolvency of the Medicare HI trust fund and this threat has triggered changes in the program (see Chart 1). For example, the Trustees' 1997 estimate that the trust fund would become insolvent in 2000, in no small measure, drove the deep cuts that were included in the Balanced Budget Act of 1997 (BBA). These cuts, strong economic growth, and aggressive efforts by HCFA, the Inspector General, and the Department of Justice to reduce inappropriate payments have pushed off the date of reckoning until around 2025. Even though there is no trust fund crisis looming in the near future, the program will impose a rapidly growing fiscal burden on the nation. Over the next decade, Part B expenditures, three-quarters of which are supported from general revenues, are projected to grow one-third faster

than the Part A expenditures that are financed through the HI trust fund. The Congressional Budget Office projects that overall Medicare spending will surpass that of Social Security sometime between 2030 and 2040. Reforms are needed to keep the program affordable. But the reform options currently being debated are not likely to achieve sufficient long-run savings needed to do the job. Both CBO and HCFA estimated that the competitive structures embodied in recent legislative proposals would generate only modest savings. Competitive approaches that might promise more in the way of long-run savings are likely to be viewed as unacceptable because they shift too much of the program's cost burden onto beneficiaries and reduce the financial security that the current program provides.

2. ***Inadequacy***: The Medicare benefit package is inadequate by the health insurance standards that prevail for the under age 65 population. It lacks coverage for most out-patient prescription drugs and imposes relatively high cost sharing requirements. It has no catastrophic cap on out-of-pocket expenditures and has very limited coverage for long-term care. The gaps in the benefit package have led the vast majority of beneficiaries—some 88 percent—to seek supplemental insurance coverage through individually purchased Medigap policies, employer-sponsored retiree policies, Medicaid, or M+C plans. This practice of dual coverage is complex, confusing, and costly. Furthermore, it is a system that is unraveling. Many employers are scaling back or dropping their retiree coverage, Medigap premiums are rising rapidly, and M+C plans are withdrawing from many markets and reducing their supplemental benefits. Any serious reform must begin by establishing a standard benefit package that the vast majority of beneficiaries consider sufficient without supplementation. Expanding the benefit package to include only prescription drug coverage will reduce, but not solve, this problem.
3. ***Inefficiency***: Fee for service Medicare, which enrolls some 85 percent of all participants, lacks strong incentives either for beneficiaries to seek or providers to supply only cost-effective care or, for that matter, only care that has a reasonable chance of improving health outcomes. Of course, many private sector health plans also suffer from this deficiency. Medicare, however, faces another challenge —setting its payments at the right level—that does not bedevil private plans to the same degree. The program pays for thousands of medical services delivered by hundreds of thousands of providers and suppliers operating in hundreds of separate market areas. Because it must operate throughout this very diverse nation, it is impossible to set uniform payment rates that will be efficient everywhere. Some providers are overpaid, others are undercompensated. Because the consequences of underpayment are so serious—denial of access to needed services for a vulnerable population—and because political pressures can affect payment policies, overpayments (rather than under payments) tend to be the norm. Of course, all complex systems tolerate some inefficiency because the costs of wringing out the excess exceeds the gain. But the level of inefficiency accepted in Medicare is higher than that in private sector plans because Medicare, being a government program, has objectives other than efficiency, such as ensuring that certain types of providers survive in rural areas. As reform options that promise improved efficiency are debated, it will be important to consider whether and how these other goals of the Medicare program will be met under a restructured system.
4. ***Inequity***: Medicare expenditures per beneficiary vary by well over two to one across the nation's counties even after adjusting for differences in input prices and the health status of each area's participants. Undoubtedly, some of this variation represents regional differences in the proclivity of beneficiaries to seek medical care. Some reflects the availability of providers, particularly those offering expensive, sophisticated diagnostic services and treatments. And some is due to geographic differences in prevailing practice patterns. To the extent that the expenditure differences reflect limited access to providers or practice patterns representing underutilization of beneficial care, inequities exist. To the extent that the variation reflects overutilization of services that do not improve health outcomes, inefficiencies exist. A reformed Medicare program must reduce these disparities. That means developing measures of the quality of care offered by both M+C plans and fee-for-service providers. Only with such indicators can the program's serious inequities be measured and corrected.
5. ***Incompatibility***: Some 85 percent of Medicare participants have their care paid for through an unmanaged fee-for-service insurance plan in which virtually all providers participate. Roughly the same fraction of the insured under age 65 population participates in a health plan in which care is managed lightly (preapproval for non-emergency hospitalization, provider profiling, etc.) or heavily, and which have incentives that steer members toward a limited set of providers. In short, the predominant forms of insurance coverage for the under and over age 65 populations have diverged significantly over the past 15 years. As a result, we can expect increasing confusion among Medicare beneficiaries, increased complexity for providers, and the erosion of political support for the program. An ideal system would be seamless. Workers covered by an employer-sponsored plan would remain in the plan they were familiar with when they retired as long as they were satisfied with the care they had been receiving. Political support for the program could weaken if the working population thought that its taxes were rising to provide the elderly and disabled with costly choices that were unavailable to them.

It will not be easy to restructure Medicare to address all five "I" problems or others that might merit attention. Reforms directed at solving one problem could exacerbate another. For example, efforts to deal with the inadequacy of the Medicare benefit package are likely to worsen the program's long-run fiscal health; attempts to make the program more efficient could exacerbate existing inequities. Difficult tradeoffs will have to be made as the reform effort moves forward.

The Budgetary Impact of a Medicare Prescription Drug Benefit

The first step toward making Medicare more efficient, equitable, and adequate is to expand the benefit package. That means including all services that the medical professions consider essential to the practice of modern medicine and for which the vast majority of Americans want protection against high out-of-pocket costs. Prescription drugs clearly fit this bill. It makes no more sense to exclude prescription drugs from the

benefit package than it would to exclude diagnostic imaging (X-ray, CT, MRI, and PET scans) or lab tests. Surely, Congress would include prescription drugs in the basic benefit package if Medicare were being enacted today.

That said, there are two difficulties with adding prescription drugs to the standard benefit package. First, a significant fraction of all beneficiaries already enjoys such coverage through supplemental policies, such as employer-sponsored policies, Medicaid, and no-premium M+C plans, which are fully or partially subsidized. (See Table 1). Understandably, these participants are not interested in paying more for a benefit they already have. Their opposition forced Congress to repeal the Medicare Catastrophic Coverage Act (MCCA), with its drug benefit, less than two years after it had voted overwhelmingly to approve the bill. But their numbers are shrinking as M+C plans withdraw from markets and scale back their drug benefits and as employers drop retiree coverage or force their former workers to pay higher premiums.

The second difficulty is that a prescription drug benefit is expensive. Small wonder considering that the elderly and disabled are very heavy users of pharmaceuticals and many of their needs stem from chronic conditions that will continue until they die.

The major plans that were debated during the 106th Congress had price tags that ranged between about $150 billion and $350 billion for the first ten years (See Chart 2). These figures, of course, understate the cost of an ongoing program because they include years in which the benefit is being phased-in. It is more revealing to look at the tenth year costs, which ranged from $27 billion to $55 billion. These tenth year costs represented an increase in baseline Medicare spending of between 7 percent and 14 percent for these proposals (See Chart 3).

Even these more realistic figures are likely to be underestimates of the costs of a politically sustainable prescription drug benefit. This could prove true because the proposals put forward last year offered very parsimonious benefits compared to those enjoyed by most insured workers and their dependents. As soon as one of these plans was enacted, pressure would begin to mount to liberalize the benefit and make it more like the ones enjoyed by workers.

For most non-aged Americans, drug coverage takes the form of "assistance" rather than "insurance." Insurance protects against large, unexpected, financially debilitating expenditures over which the insured has little control. Large deductibles, low co-insurance rates, and stop losses (out-of-pocket limits above which insurance picks up all the costs) characterize pure insurance—from which a relatively few benefit in any year. Assistance, by contrast, spreads benefits widely, providing partial coverage for routine expenditures and deeper coverage for large, unexpected expenditures. There are low or no deductibles under assistance and most participants receive some benefit each year.

For most Americans, therefore, an adequate prescription drug plan is one that requires only a small copayment—say somewhere between $5 and $25 per prescription— or 20-percent coinsurance on drug expenditures that exceed a modest annual deductible of $50 to $100. The proposals considered by the 106th Congress, like the prescription drug component of the Medicare Catastrophic Coverage Act of 1988 (MCCA), are a far cry from this definition. Under the MCCA, the deductible was set each year at an expenditure level that only one-sixth of all beneficiaries would exceed. Eighty percent of expenditures above that level—which would have been about $1,700 in 2000—were covered by Medicare.

The proposals now on the table would provide most Medicare beneficiaries with more generous coverage than did the MCCA but these plans would still impose a significantly higher burden on participants than does the average employer-sponsored plan. Under former Vice President Gore's plan, a beneficiary with $3,000 in prescription drug expenditures in 2003 would have had to pay $1,874 out-of-pocket in premiums and coinsurance.** The plan proposed by Senators Graham and Bryan would have required out-of-pocket expenditures for premiums, the deductible, and coinsurance of $2,091. The comparable figure for the proposal of Senators Breaux and Frist and the House-passed plan would have been $2,435 (See Chart 4).

Viewed another way, the beneficiary would be paying out-of-pocket for premiums, deductibles, and coinsurance an amount that exceeded 50 percent of the total cost the drugs purchased until those costs exceeded $7,900 under the Gore plan, $8,900 under the Graham/Bryan proposal, and $12,900 under both the plan passed by the House and the one proposed by Senators Breaux and Frist (See Chart 5).

Few working Americans would be satisfied with such coverage for themselves or their parents. Therefore, Congress should expect unrelenting pressure to improve the drug benefit that is initially enacted if it is not significantly more generous than the plans introduced in the 106th Congress. As this Committee weighs the budget recommendations that it will make to the full Senate, it should consider realistic estimates of what a politically-sustainable Medicare prescription drug benefit will cost over the next decade.

Table 1
Prescription Drug Coverage of Medicare Beneficiaries, 2000

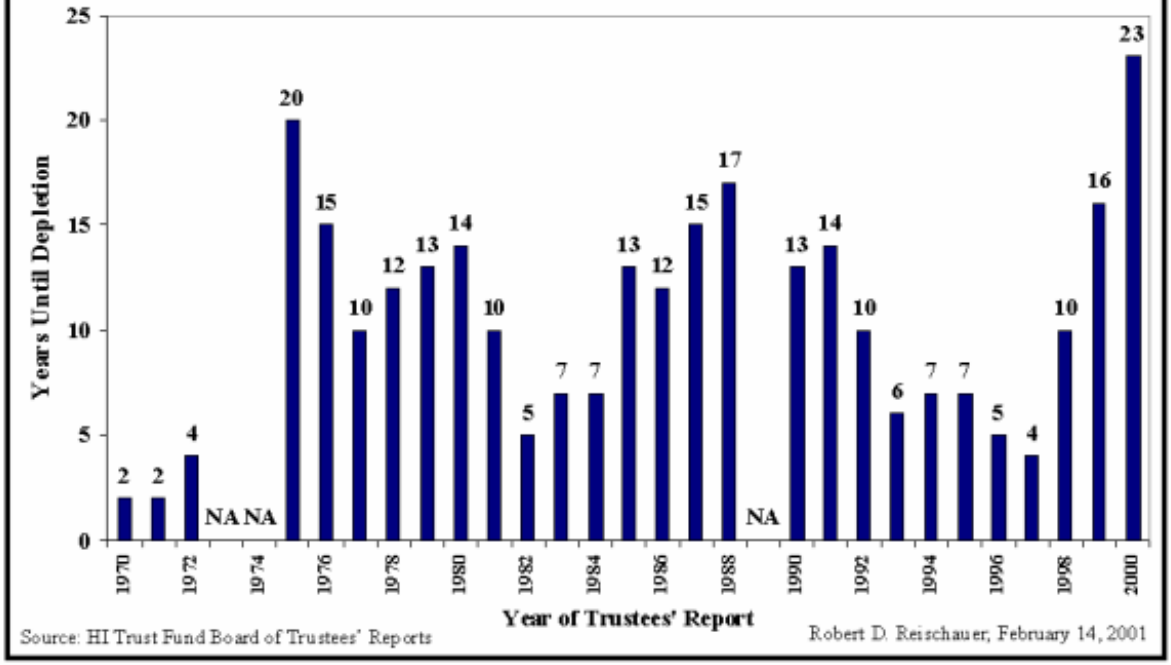
No Drug Coverage	34%
Employer-Sponsored	24%
Medicare HMO	12%
Medicaid	8%
Medigap	17%
Other*	5%
Total = 40 million Medicare beneficiaries	

*Includes other public programs such as Veterans Affairs, Department of Defense, and state pharmaceutical assistance programs.

under M+C plans. MCBS '95, trended forward and adjusted for under-reporting and insurance composition. Numbers may not add to 100% due

Source: Actuarial Research Corporation/Health Policy Alternatives analysis of Medicare prescription drug proposals for the Henry J. Kaiser Family Foundation, 2000.

Chart 1
Projected Years Until Depletion of Medicare HI Trust Fund



Source: HI Trust Fund Board of Trustees' Reports

Robert D. Reischauer, February 14, 2001

Chart 2

CBO Cost Estimates for Prescription Drug Bills (Including Medicaid Impact)

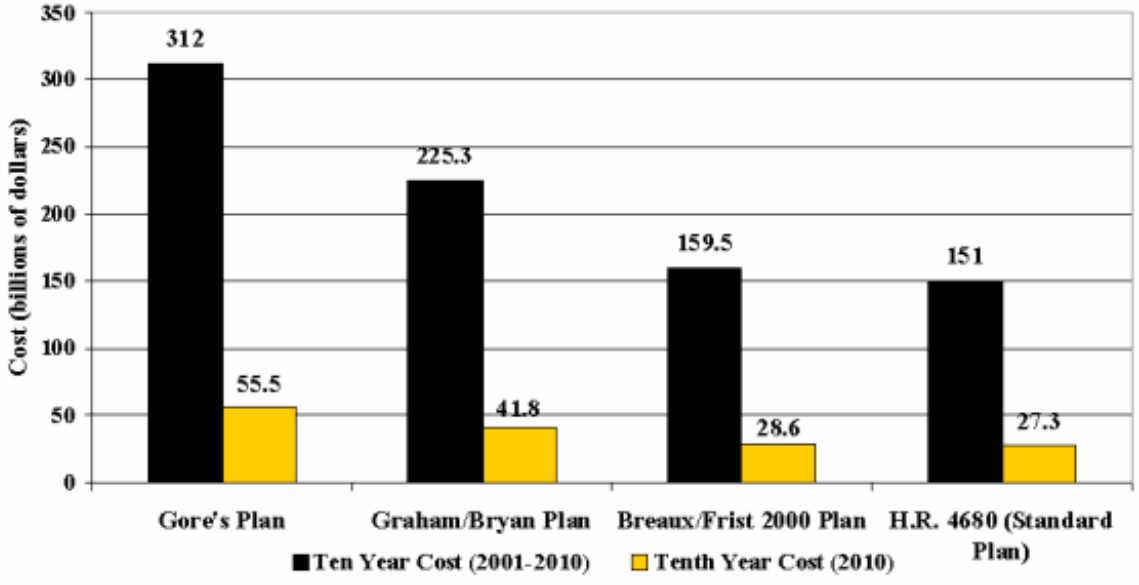


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Chart 3

CBO Cost Estimates for Prescription Drug Bills as a % of Projected Medicare Spending (Including Medicaid Impact)

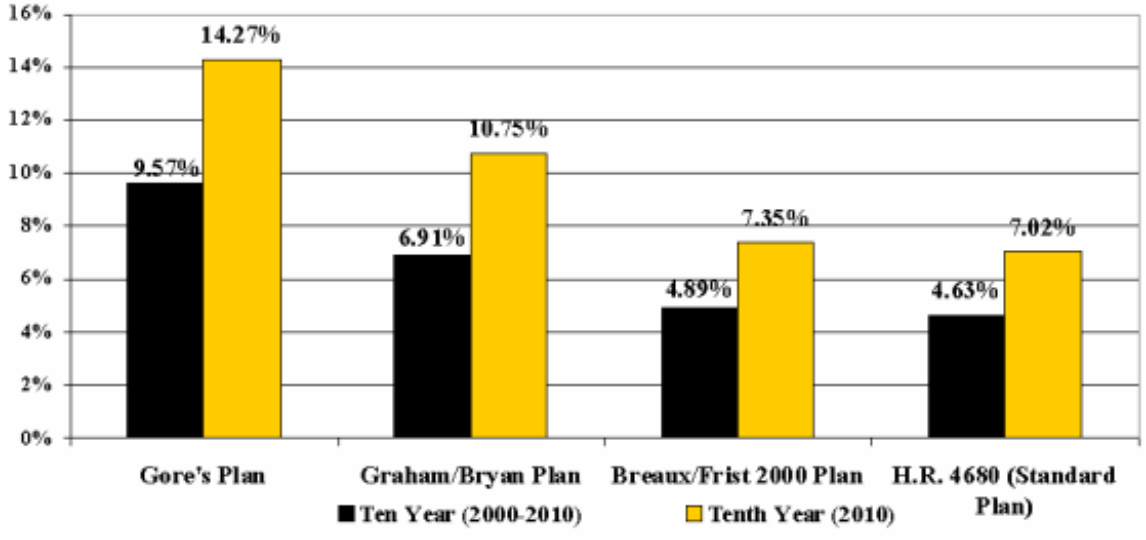

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Chart 4

Out-of-Pocket Rx Expenses Including Premiums as Total Rx Expenditures Rise (2003)

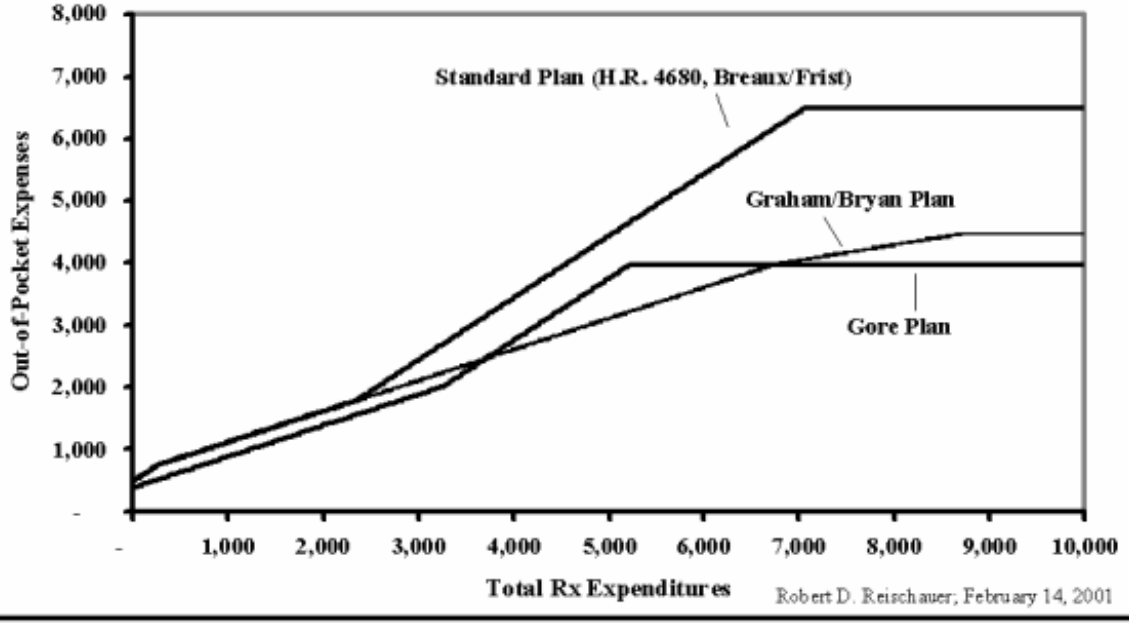

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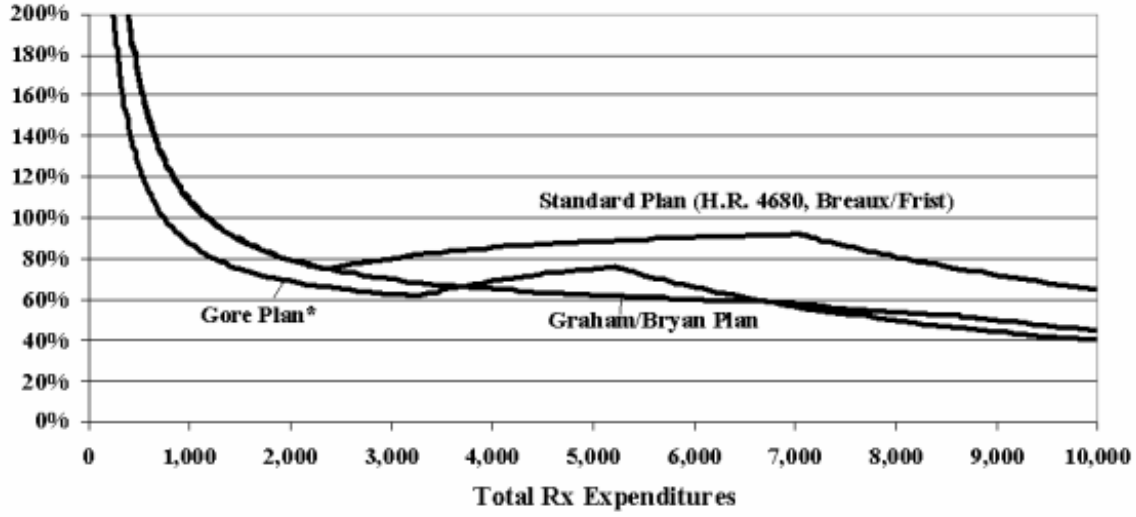
Chart 5

Beneficiary Premiums, Co-Insurance, and Deductibles as a % of Total Rx Expenditures under the Gore Plan*, the Standard Plan, and the Graham/Bryan Plan (2003)



*2008 values for fully phased in benefits scaled back to 2003 values

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Notes

* President of The Urban Institute and Chair of Steering Committee for the Restructuring Medicare for the Long Term project of the National Academy of Social Insurance. The views expressed in this statement should not be attributed to the Urban Institute, the National Academy of Social Insurance, their sponsors, staff, or trustees.

** For comparison with the other proposals, it was assumed that the benefits in the Gore proposal, like those in the other plans, were fully phased-in by 2003.

Other Publications by the Authors

- Urban Institute