Issue Focus: Social Security

Testimony before the House Ways and Means - C. Eugene Steuerle

Urban Institute

Document date: January 01, 2001
Released online: January 01, 2001

Chairman Nussle, Congressman Spratt, and Members of the Committee: Thank you for the opportunity to testify today on Medicare reform issues. This is, as the budget blueprint introduced by President Bush says in its introduction, "an unprecedented moment in history." The federal government now has the financial ability to make needed changes in Medicare, including adding prescription drug benefits, and to put the program on a stronger financial footing. But the administration's blueprint does not acknowledge the full extent of what is needed for Medicare.

After reviewing some of the specific issues raised in the blueprint, I concentrate on prescription drug issues because this is a reasonable place to start on improving Medicare for the future. It is essential for most other types of reforms. And to address this issue effectively, sufficient resources need to be reserved for this task. I also emphasize issues facing the traditional fee-for-service part of the program, which serves 34.4 million of the 40 million Medicare beneficiaries but is often ignored when the discussion turns to "reform." For the foreseeable future, traditional Medicare will serve the majority of beneficiaries and an even larger majority of older and sicker beneficiaries. Improvements in traditional Medicare should be an important part of any reform effort.

Budget Numbers and Issues in the Blueprint

The Bush administration's blueprint for the budget recognizes some of the important issues facing Medicare in the future. Medicare was singled out by President Bush during the campaign and again in the budget submission as a program in need of expansion, particularly with respect to prescription drug coverage. The principles laid out in the document also indicate that Medicare's guarantee of access must be preserved, both in general and with respect to new technological advances, and that additional protections are needed for low income beneficiaries. All of these are laudable goals.

Further, it is appropriate to consider both Parts A and B of Medicare when examining the costs of serving the elderly and disabled. But the blueprint document goes further and treats Part B as if it were in deficit because it relies on general revenue financing. General revenues have been a major funding source for Medicare since its passage in 1965 and that obligation is spelled out in statute. It makes no sense to treat Part B as in "deficit" and thereby imply that payroll taxes should support both Parts A and B. Such an argument makes no more sense than assuming that spending on Medicaid, Veteran's benefits or even defense should be covered by the Part A Trust Fund. All of these other sources of spending have no more legal claim on general revenues than does Part B.

Coupled with the blueprint's pledge not to raise payroll taxes, if general revenues are excluded, there is no way that there will be enough revenue to support existing benefits beyond about 2005.[2] And certainly there will not be enough revenue from 2.9 percent of payroll to cover the increasing number of people who will be eligible for the program at the end of the decade or to fund a prescription drug benefit.

Part of the case made in the document for combining A and B in examining Medicare is a criticism of the shift of some home health benefits from Part A to Part B in the Balanced Budget Act of 1997. This change, which returned home health closer to how it was treated in 1966, did make Part A look better. But it is incorrect to argue that it "had no economic consequences." By shifting a majority of home health care to Part B, beneficiaries costs rise since their Part B premium is 25 percent of the costs of Part B services. Thus, this was an indirect, but intended, increase in beneficiary contributions. In fact, beneficiaries' share of combined A and B spending will rise from about 9 percent prior to the BBA to over 11 percent when the phase in of home health is completed in 2004. Over the ten year period, that translates a per capita premium increase of nearly $1200. Most beneficiaries would not consider this a meaningless change; indeed they would likely welcome having home health returned to Part A.

This is not to say that only Part A should be considered in examining Medicare but rather that both parts should be considered with regard both to their spending *and* sources of income. Should there be limits or constraints on general revenue contributions to Medicare? Even those who have implicitly argued for such a limit have never proposed reducing general revenue contributions to zero.

At a time when both President Bush's document and most policy makers recognize that new benefits need to be added to Medicare and that the aging of the Baby Boom generation pose new demands on Medicare, it seems foolish to deny general revenue spending *and* pledge that payroll taxes will not be raised. More willingness to raise revenues is needed to assure Medicare's future. The information in the budget blueprint does a disservice to that effort.

Prescription Drug Issues

Three basic approaches to adding prescription drug coverage for Medicare beneficiaries have been suggested:

- Provide coverage only for those with low incomes—either as an initial step or as the full response;
- Provide universal coverage, but only in concert with other reforms, such as relying on private insurance plans; and
- Provide universal coverage that are not contingent upon other reforms.

The obvious advantage of offering coverage only to low-income people (as the Bush administration has proposed for the next four years) is cost. But this seemingly low cost approach requires a separate administrative structure (most likely state run) to determine eligibility and the menu of drugs that would be covered. This structure will take time to build and may be problematic if the program is only intended to last for several years. But, most important, a low income approach would solve only part of the problem because many beneficiaries who would not qualify face high costs and no access to reliable insurance.

The main reason to tie drug coverage to other reforms is to create a warmer reception for what may be very unpopular new requirements in other areas of Medicare. This has been the stance of some who propose further privatization of the Medicare program. But a drug benefit would likely be stalled while controversies over the role of traditional Medicare and private plans are worked out. Meanwhile, the plight for beneficiaries will worsen each year. Another risk of this approach is that a drug benefit would be designed that works well with private plan options, but treats coordination with the traditional Medicare program as an afterthought.

The approach I favor would deal with the prescription drug issue now, perhaps in conjunction with some other changes in Medicare, but not a full restructuring of the program. Getting it right on prescription drugs is a large task by itself. Regardless of whether the future of Medicare relies on incremental reforms or program restructuring to feature private insurers, a drug benefit is a necessary first step. Moreover, since both traditional Medicare and private plans are likely to be part of the future, any drug benefit needs to work under either scenario.

Is the $153 billion proposed in the budget blueprint enough to fund a reasonable Medicare prescription drug benefit? If the costs of prescription drugs rise at the rate that the CBO estimates over the next ten years, $153 billion will cover a benefit that is less than 10 percent of drug spending by Medicare beneficiaries, not enough to offer the type of protection that beneficiaries need or expect. On the other hand, if the administration's $153 billion number is a net figure after achieving substantial (but as yet undefined) savings, perhaps the amount to be contributed would be much higher. Even if the number were doubled to $300 billion, however, this would only raise the contribution to an average of about 20 percent of costs of drugs, and it leaves unknown where the $150 billion in additional savings would come from.

Prescription Drugs and Medicare Beneficiaries. Prescription drugs are the primary acute care benefit excluded from Medicare coverage. Only in the hospital, a nursing home, or in a hospice will Medicare cover drugs. But drugs are now, more than ever, a critical part of a comprehensive health care delivery system. Lack of compliance with prescribed medications can raise health care costs over time. And for many who need multiple prescriptions, the costs can be beyond their reach.

An initial look at supplemental coverage might suggest that there is little need to expand benefits, except perhaps for those with very low incomes. True, many beneficiaries do have supplemental insurance plans. But, if the reliability of insurance is taken into account, many more have unmet needs. Medicare beneficiaries supplement their basic benefits from four sources. The first two, employer-based retiree insurance and individual supplemental coverage (which is referred to as Medigap), are provided by private insurers, while Medicaid, a public benefit, subsidizes many low-income beneficiaries. Fourth, Medicare contracts with private plans, mostly health maintenance organizations (HMOs), to serve beneficiaries who choose to enroll. Such plans often cover services that basic Medicare does not. Such supplemental coverage varies in quality, beneficiaries' access, and the degree to which the added coverage relieves financial burdens. Only employer-based retiree coverage and Medicaid offer reliable drug benefits, and even then not to all their enrollees.

Employer-based plans normally offer comprehensive supplemental insurance, including drug benefits, and subsidize retirees' premiums. Thus, these plans both reduce out-of-pocket expenses and increase access to services. But such plans are limited to workers and dependents whose former employer offers generous retiree benefits. As a consequence, these benefits accrue mainly to higher income retirees.

Medicaid, which also offers generous "fill in" benefits, including drugs, is limited to persons with incomes well below the federal poverty level. low incomes. Since Medicaid is a joint federal/state program, states have latitude in establishing eligibility and coverage. And although all states cover prescription drugs, many have

limits on who is eligible and what drugs are included. Concern about the high costs of prescription drugs suggests that states are unlikely to expand these benefits on their own, (although some are active in providing separate drug programs).

Medigap plans are rarely a good bargain for most beneficiaries. Beneficiaries pay the full costs of such plans. Medigap options that include drugs have become prohibitively expensive for many beneficiaries, particularly the very old who must pay substantially higher premiums than those aged 65 to 69, for example. And even though they can charge steep premiums, many insurers are refusing to offer options with drug coverage. Most likely, Medigap drug coverage will soon be viable only for those who have been grandfathered into a reasonable plan.

Finally, beneficiaries can opt to go into a Medicare + Choice plan. These private plans generally offer additional benefits at a lower cost than Medigap does, but require enrollees to meet certain conditions, such as agreeing to go only to doctors and other care providers who are on a prescribed list. Since 1997, these plans have either shrunk their benefits packages or raised premiums (over and above Medicare's Part B premium). Drug coverage has either been dropped altogether or stringent caps have been placed on the amount covered. Moreover, a number of plans have pulled out of Medicare, causing beneficiaries to scramble for new arrangements.

In sum, while a substantial number of beneficiaries now have drug coverage, the share with reliable coverage (employer-based or Medicaid) is considerably smaller. Only 39 percent of Medicare beneficiaries have reliable coverage, and an even smaller percentage have it for a full year. Further, states and former employers who now support good coverage may pull back as prescription drugs become even more expensive, intensifying demand for drug coverage in the future. Figure 1 indicates how vulnerable beneficiaries are. It identifies those most in need of coverage across different levels of economic status (shown as income as a share of the poverty guidelines). The white areas stand for beneficiaries who have no coverage or who now rely on Medigap or Medicare+Choice plans.

As Figure 1 also shows, in all groups a majority of beneficiaries is without reliable coverage. Cutting benefit eligibility at 135 percent or 175 percent of the poverty level would not do away with the problems that beneficiaries face of obtaining reliable prescription drug coverage. In fact, the group with incomes between 175 percent and 250 percent of poverty (about $15,000 to $20,000 for a single person) get little coverage from either employer-subsidized or Medicaid coverage. They are in many ways as vulnerable as the truly poor. If eligibility extends to 250 percent of poverty, that would include over 60 percent of the Medicare population. And even of those with incomes above 250 percent of poverty, only 41 percent have reliable coverage.

Spending on drugs, on average, is about the same across all income groups. In other words, the importance of this benefit does not decline with income, although the ability to pay does improve. And, even more important, the burdens on Medicare beneficiaries will continue to rise, even with no policy changes. Figure 2 projects out-of-pocket spending for several groups of beneficiaries. Much of the growth in out-of-pocket burdens over the next 25 years reflects growth in the cost of prescription drugs.[3]

Issues Crucial to Beneficiaries. As shown above, prescription drug costs are a large and rising expense that many beneficiaries must face. The willingness of Medigap beneficiaries to pay high amounts to obtain drug coverage and of Medicare+Choice beneficiaries to enroll and switch plans to obtain drug coverage suggest how much beneficiaries value this benefit. It is likely, then, that they would pay higher premiums to obtain this coverage. But, low income protections and a universal subsidy would be needed to make this an effective benefit.

If the drug benefit is to be a voluntary option, a subsidy and some enrollment restrictions would be even more important to insure that a broad range of beneficiaries would join the Medicare plan. Consider Part B of Medicare. It is a voluntary benefit, but a subsidy makes it sufficiently valuable to attract almost all beneficiaries. As a consequence, risk selection does not raise the costs of the coverage.

The structure of any prescription drug benefit will affect access and use. If a standard drug benefit were offered as an option through the Medicare program, the administration of the benefit could be contracted out to private companies just as Medicare now does for its payments to hospitals, physicians and other providers. This approach hews closely to the practice of the basic Medicare program.

Alternatively, the private sector could be used to establish voluntary prescription drug options. Usually this tack is proposed as a way to allow coverage to vary from plan to plan and across the country. But this private option works better for enrollees who choose to be in private plans than for those in traditional Medicare because the latter would face confusing choices. Already, most beneficiaries have two types of insurance. Adding a third separate benefit, run by yet another insurer, would undoubtedly add to the complexity and confusion that already plagues many beneficiaries. Breaking up coverage makes little sense from an insurance standpoint—one reason why the insurance industry has not been interested in stand-alone drug plans.

Further, even for those in private plans, permitting variation in benefit packages offered creates a serious disadvantage. Allowing individuals to choose what is "best" for them is likely to separate the sick from the healthy and make it difficult to make sure that the neediest can afford coverage. Most Medicare beneficiaries who expect to use few drugs would choose a plan with no deductible, low co-insurance, and a low cap on benefits. Those who anticipate using more or higher priced drugs might want greater overall protection even if they have to pay a deductible or high coinsurance rate for their initial purchases. A standardized benefit takes away one tool for achieving risk selection.

Finally, the generosity of the plan is a critical element. Even the most generous plans will not be as

comprehensive as what most younger families have, even though the needs are greater for Medicare beneficiaries. Protections ought to be generous enough to be valued by those who enroll, although the costs of a drug benefit are likely to be high and grow rapidly over time.

Other Reform Issues

Drug coverage represents a logical first step in reform, helping to smooth the way for other Medicare changes. It also makes sense to carry out some other reforms simultaneously, and put in place changes that may pave the way for later, more extensive changes.

Improving the Traditional Medicare Program. One major criticism leveled at fee-for-service Medicare is that when it is combined with supplemental insurance, many beneficiaries have nearly first dollar coverage. If beneficiaries face cost sharing requirements, that might make them more conscious of the costs of care. The Congressional Budget Office has long contended that this approach substantially raises the costs of Medicare. Further, dual coverage generates excess administrative costs that beneficiaries must cover.

Adding prescription drug coverage would reduce the need for other supplemental insurance, but probably not enough to encourage beneficiaries to drop their Medigap plans. Other changes in cost sharing would be needed, such as reducing the very high Part A deductible and limiting the total amount of cost sharing that any beneficiary would owe. A more rational Medicare cost-sharing package would not have to be an expensive addition, especially if it increased cost sharing in such areas as the Part B deductible that are low compared to the private sector. These changes could help defray higher costs elsewhere. If the basic Medicare benefit could be made to look more like insurance that most working families have, with good protections and reasonable cost sharing, the traditional Medicare program could satisfy both beneficiaries and those worried about costs.

In addition, moving more basic health care services under the Medicare umbrella would substantially better protect sicker and older beneficiaries. The very old get Medicare at community rates (i.e. where everyone pays the same premium), but they depend more on Medigap for their supplemental coverage even though these policies are age rated and hence are very costly. These beneficiaries are least able to afford Medigap premiums and could benefit if they were covered under Medicare instead. And in the case of younger disability beneficiaries, Medigap is often not available at all.

Another advantage of expanding the traditional Medicare benefit package is that further reforms that might coordinate care through disease-management or other programs can be effective only if the full range of care is available. The lack of prescription drug coverage and the reality of very high out-of-pocket costs increases the likelihood of non-compliance. Such non-compliance would make it hard to achieve overall savings since the extra expense of coordination of care would not be offset by better outcomes. For example, it makes no sense to have a program to control hypertension if beneficiaries cannot afford the drugs necessary to combat hypertension.

Finally, the current Medicare+Choice plans are able to offer prescription drug benefits in part because they receive federal payments in excess of what it costs to provide the current Medicare benefit package. The General Accounting Office has found that plans get payments more than 13 percent higher than what it would cost in fee-for-service to provide the basic benefits. Even the HMO industry now makes its case for higher payments over time as necessary to retain a "desirable" benefit package—not just the required Medicare benefits. The problem is that many of the 6 million beneficiaries in HMOs thus get subsidies for drug coverage, but those in traditional Medicare—who are sicker on average and more likely to need drugs—do not. Adding a prescription drug benefit to Medicare would help both Medicare+Choice enrollees and those in traditional Medicare. And since partial subsidies are already in place for HMOs, accounting for this could lower the costs of providing universal coverage.

In addition to improvements in Medicare from adding a drug benefit, other modernization efforts will be important as well. The administration's criticisms of the current program and call for "modernization" can be viewed as a need for restructuring or as a call for improving the current system. The latter effort should be undertaken regardless of what happens in restructuring of Medicare.

Much of the administration's criticism about Medicare centers on complexity and bureaucracy. Certainly the Health Care Financing Administration's (HCFA) operations should be improved. But it is also important to determine what the problems are and how to solve them rather than just pinning the blame on government bureaucracy. Over the years, the responsibility of HCFA has grown substantially, but its resources to deal with these responsibilities both in dollars and personnel have not expanded. Second, the Congress has taken a strong interest in Medicare and dictated many policies at a very disaggregated level.

It is important to note that few private insurance companies escape problems of complexity and bureaucracy. Many workers and their families find the requirements of their plans to obtain approval before getting some services, to determine which doctors and hospitals are in network and which are not, understanding the bills when they come due months later, and the need to appeal denials of care to be cumbersome, complex and overly bureaucratic. Thus, problems with the complexity of our current health care system are by no means inherent only to government. The goal should be to reduce these burdens throughout health care, but to lay the issue at the doorstep of only Medicare is misleading. More resources are needed to expand oversight capabilities and bring in professionals who have private sector experience.

Further, the traditional Medicare program needs to have more flexibility to deal with providers of care and make judgement calls that the Congress has often prevented. Experiments with new ways to coordinate care in a fee-for-service setting need to be undertaken. Improved methods of payment to private plans and better

measures to control for risk selection are needed both in the current system and are necessary before beginning a more extensive restructuring effort. Relying on private plans to make decisions is unlikely to result in the government observing a hands-off approach. Nor should it. Medicare is an important program that needs careful oversight to protect the beneficiaries it serves.

Restructuring Options that Rely on the Private Sector. Proposals to rely more upon the private market to offer coverage to Medicare beneficiaries would also be helped if a reasonable prescription drug benefit were in place. Not only does managed care need a comprehensive benefit package to perform well, but such a benefit would help reduce the incentive for risk selection that private plans now face. Plans would find it difficult to voluntarily add any benefits—such as drugs -- without attracting sicker patients. They would likely respond in the same way that current Medicare+Choice plans have responded by paring back drug coverage.

For these reasons, competition will work much better if the basic plan that all must offer is sufficiently comprehensive and standardized. This would still leave ample room for adding other benefits or competing on price. Until adjustments that could account for differences in health status are improved, it will be difficult to use competition in positive ways. The benefits to plans of seeking good risks are simply still too tempting. It is easier to make profits by attracting healthy patients than by coordinating care.

Some of the steps described above in connection with reforming the current program need to be in place and working well before a full restructuring of Medicare is undertaken. This is particularly the case if traditional Medicare is put at risk and becomes inordinately expensive over time. That would harm the most vulnerable beneficiaries, offsetting any gains that might result in improved efficiency or choice. Further, concerns raised about managed care for younger Americans and the issue of whether such an approach can actually offer cost savings need to be addressed before making aggressive moves toward this type of change. Figure 3, for example, compares Medicare per capita growth with growth in spending by private insurance over nearly a thirty years. Medicare's track record is substantially better than the private sector.

Improving Beneficiary Education and Information. Another factor important to the success of Medicare reform is to give beneficiaries more say in decisions about their own care. But simply giving them responsibility (for example, requiring them to choose a plan) will not work unless they have the tools to respond. Credible, independent sources of information will be essential.

A good place to start this educational effort would be with the prescription drug benefit. A publicly funded but independent organization that would provide information on the quality of generic drugs and the extent of equivalence across name brands in the same drug categories, for example, could help beneficiaries to make more informed choices. Reassurance that a less expensive drug is just as effective will be more powerful coming from a credible source than from a plan with a financial stake in that decision. Prescription drug coverage will be expensive; so government should invest in the resources necessary to make better decisions. This information could also help hold down costs of drugs both in Medicare and in the private sector.

Financing. Expanding benefits is a separable issue from how the structure of Medicare evolves over time. It is *not* separable from the issue of the cost of new benefits, however. Adding drug coverage clearly raises financing issues. New revenues, most likely from a combination of beneficiary and taxpayer dollars, will be required. The administration's proposals ignore this key issue and in fact make it worse by treating general revenue as "deficit" financing and arguing for no increase in payroll taxes. No restructuring effort or other reform will be sufficient to remove the need for greater resources over time.

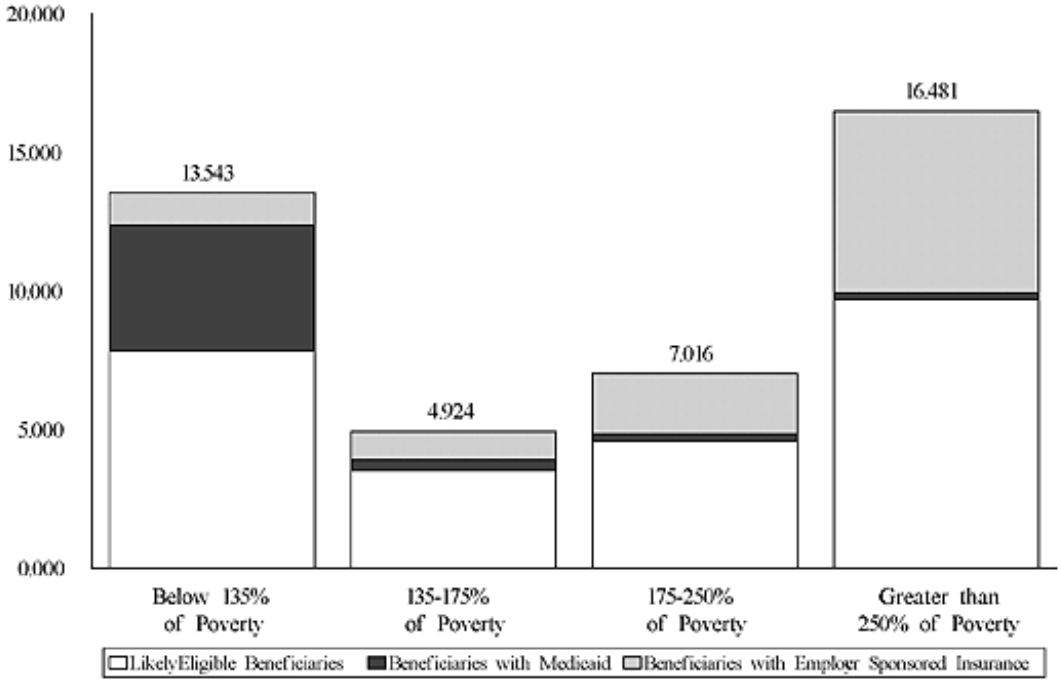
Conclusion

A familiar refrain for critics of Medicare is that it is a "Cadillac" program, but the model year is 1965. This criticism is often leveled at Medicare's fee-for-service system. In fact, the Medicare delivery system has undergone a large number of changes and reforms. In the 1980s, it was a leader in pushing for payment reforms and its per capita growth rates were lower than that of private insurance. It now has a private option dominated by managed care plans, and increasingly reforms have sought to give administrators of the program further flexibility in managing the costs of care. Where the criticism is more on target, however, is in the area of benefits. The basic structure of the Medicare benefit package has changed little since 1965.

The current patchwork approach to provide drug benefits through private insurance, such as we have now, is seriously flawed. Prescription drug benefits generate risk selection problems; already the costs charged by many private supplemental plans for prescription drugs equal or outweigh their total possible benefits because such coverage attracts sicker than average enrollees. A concerted effort to expand benefits is necessary if Medicare is to be an efficient and effective program. This commitment will require substantial new resources, but adding a prescription drug benefit is a logical place to begin reforms of Medicare. It does not make sense to hold beneficiaries hostage in order to pass other unpopular and unproven changes in the program.

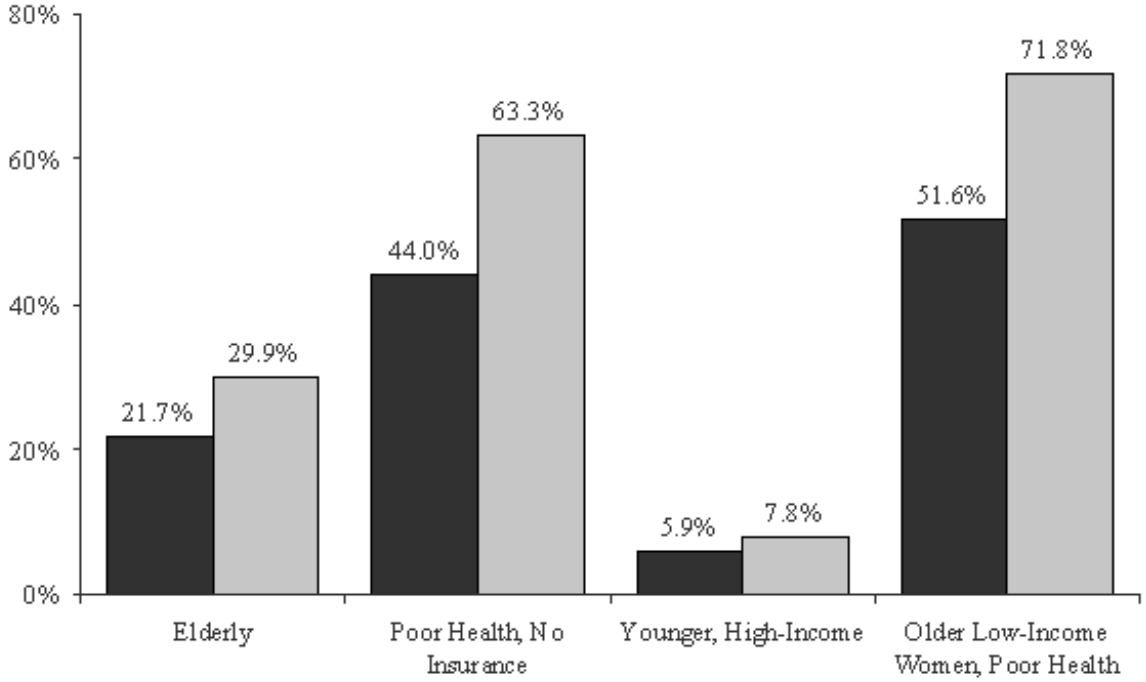
Too often the solution proposed to complexity or inefficiency is to start over with a whole new system. But that approach carries no guarantees of success. Improvements in the current Medicare system could test out whether more restructuring will work well for Medicare beneficiaries. There is a great deal to do before major reforms are ready for "prime time."

Figure 1
Number of Beneficiaries by Eligibility Status, 2002 (in millions)



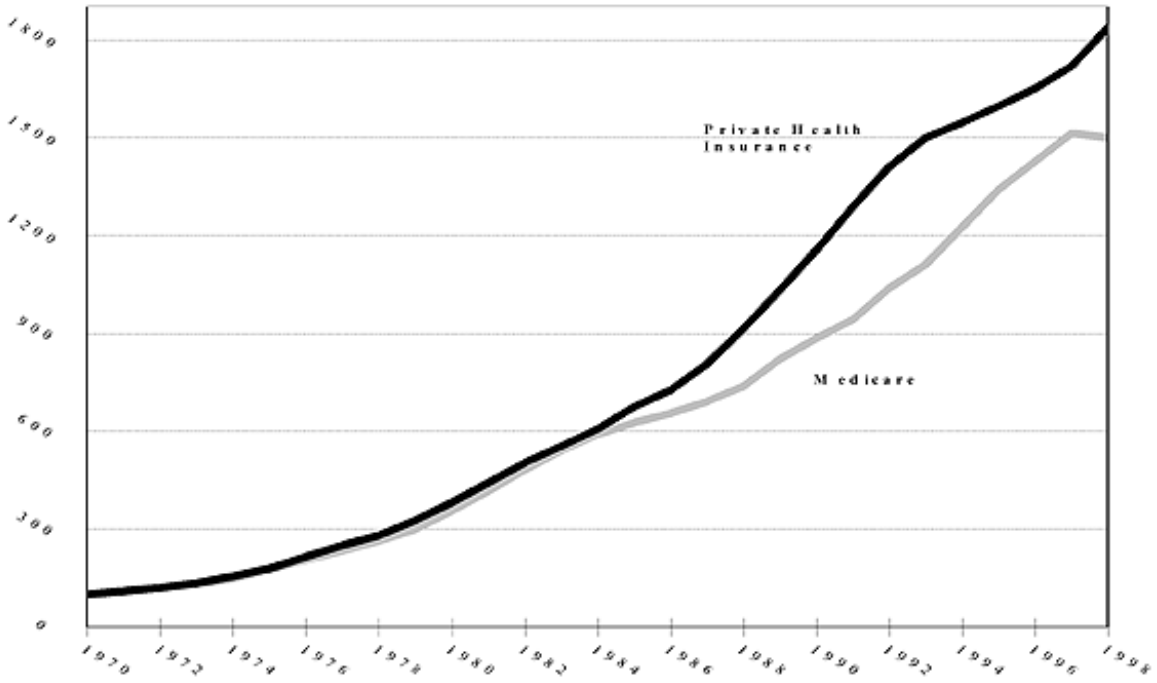
Source: Urban Institute Analysis of the 1997 Medicare Current Beneficiary Survey

Figure 2
Projected Out-of-Pocket Spending as a Share of Income Among Cohorts, 2000 and 2025



Source: The Urban Institute's 1999 Medicare Projections Model

Figure 3
Cumulative Per Capita Rates of Growth in Health Care Spending, 1970-1997



Source: The Urban Institute's Analysis of National Health Expenditure Data

Notes

1. Senior Fellow, The Urban Institute. The views expressed herein are those of the author and do not necessarily reflect those of the Urban Institute, its trustees, or its sponsors.

2. This is based on last year's Trustees numbers. The outlook would likely be a little better this year, but not by very much.

3. Although these numbers are dramatic, they still may understate possible increases in out-of-pocket costs. For example, we do not assume changes in insurance coverage over time, and we assume relatively modest drug growth of 10 percent per year for 10 years and then the same growth rates as for other health care services.

Other Publications by the Authors

- Urban Institute