Medicare Reform: Modernizing Medicare and Merging Parts A and B

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Mr. Chairman and members of the Committee: I appreciate the opportunity to be here today to testify on issues of combining Parts A and B of Medicare. As you are well aware, there are many different reasons why people have advocated such a combination over the years. In my testimony, I examine a number of the goals that people have expressed, consider whether it is necessary to combine Parts A and B to achieve those goals, and suggest other remedies that are also important to consider for modernizing Medicare. I conclude with several cautions about problems that such a combination could create.

A Brief Look at the Medicare Program

It is instructive to look briefly at the history of Medicare and consider why there are two parts of the program. Until very late in the legislative process, only Medicare Part A was under consideration. In the private sector, many people who had health insurance had it only for hospitalization. As the most expensive part of health care, it was considered the highest priority for an initial insurance program for the elderly. Thus, the separation occurred in part because of the last minute inclusion of Part B. In addition, by making this a voluntary program and requiring beneficiary premiums, it was thought to be more acceptable to physicians leery of participating in a government program. It appeared to be more like insurance and indeed was established with rules for a "hands off" approach to the practice of medicine.

Ironically, in the beginning, the Part A deductible of $40 was less than the $50 deductible for Part B. But Part A was indexed to the growth in hospital spending while Part B has only been subject to two discreet increases. Today at $792, the Part A deductible is much higher than the $100 Part B deductible, even though many advocates of cost sharing would likely propose that the Part B deductible be the higher one. While many observers of Medicare have appropriately suggested that the benefit package is outmoded and inadequate, those criticisms are directed more at the lack of upper bound protections and prescription drug coverage in the basic package of benefits that Medicare covers.

Medicare has always relied upon private entities to process claims and perform other insurance functions. Intermediaries serve Part A of Medicare, while Part B uses Carriers. But even beyond the titles, there are many aspects of Medicare contracting that can and should be considered in reform. But it is not just the A/B distinction that matters; restrictive rules on who can have these contracts, prohibitions against profits, and limitations on the Health Care Financing Administration's ability to seek improvements in performance are also major issues.

Although Part B of Medicare is voluntary, nearly all those eligible pay the premium and participate in the program. The subsidy makes this coverage a good deal for the elderly and disabled. Four groups make up most of those who choose not to participate: those with very low incomes who cannot afford the Premium (and who do not get help from Medicaid or related programs), those just coming on to Medicare who have not yet enrolled, federal retirees who enroll in an HMO under FEHBP, and those whose current employer (or spouse's employer) provide health insurance that is primary to Medicare. This latter group almost always fares better by relying on that private insurance for Part B-type services. And because their enrollment in the private sector saves money for the program, these individuals are not required to pay a penalty to enroll in Part B when they give up that private insurance.

The Goals

Combining Parts A and B of the program has often been suggested as part of other reforms, at least implicitly suggesting that much of the confusion and complexity is due to this particular split. Further, even larger goals -- such as financing of Medicare -- have also been linked to the importance of making such a change.

Four of the important goals mentioned are:

- Simplifying the program;
- Improving cost sharing and making it more rationale for beneficiaries;
- Achieving greater efficiency in the management of the program;
- Treating the Medicare program as a whole in considering financing issues.

These are laudable goals and need to be part of reforms that seek to make Medicare work better for beneficiaries, providers and taxpayers. But in many ways they go well beyond what can be achieved with combining A and B. Indeed, there is a danger in seeing that change as a major contribution and ignoring other key issues necessary to meet these goals.

Simplifying the program. Medicare beneficiaries are often confused about the Medicare program. They do not focus on the split between A and B; indeed, the terminology is confusing. But since most of them are in both parts of the program, this is not particularly a problem in and of itself. Further, the new Medicare+Choice option added a confusing Part C to Medicare.

Confusion arising about contacting intermediaries or carriers might be reduced with a A/B merger. However, problems for beneficiaries in getting help for the Medicare program goes well beyond confusion over who to contact. A modern, consumer-friendly program needs substantial resources and a commitment to simplifying customer service from the perspective of the consumer. Even a very complicated program can establish a single point of contact with well-informed workers helping Medicare beneficiaries with problems. If that is the real goal, the A/B issue essentially becomes irrelevant. Instead, it is the resources and commitment to improvement that need to go into the development of such a framework that matter.

Improving Cost Sharing. The purpose of cost sharing is presumably to make the user of health services more aware of costs and to discourage unnecessary use. For persons with employer-provided insurance this usually means an initial, modest deductible (or sometimes two) and then limited copays, usually for specific services. For example, some plans have high coinsurance for non-emergency use of hospital emergency rooms. Almost all have an upper bound on what their enrollees must pay out of pocket (called a "stop loss"). These cost sharing conventions have changed and evolved over time, but Medicare has retained essentially the same structure since 1965.

The combination of deductibles and coinsurance for Medicare represents an ad hoc collection of payments with little defensible justification as points of control for the use of health care services. As mentioned above, cost sharing under Medicare is essentially a historical artifact. And since its inception, little careful attention has been devoted to updating it to reflect cost sharing structures found in other health plans. It is not the fact that there are two deductibles that makes Medicare unusual, but rather that the Part A deductible is so much larger than that for Part B. Elsewhere, insurers often recognize that physician services tend to be more subject to discretion than hospital care and hence establish a higher deductible for physician services.

Another way in which cost sharing is unusual in Medicare is the linkage of the hospital deductible and coinsurance to a "spell of illness" and imposition of the coinsurance only after 60 days. This sets cost sharing highest for those who are sickest. The same problem arises with skilled nursing facility coinsurance. In addition, totally missing from Medicare is any upper bound limit on cost-sharing liabilities. Most private plans offer such "stop loss" protection so that once patients have spent a certain amount out of pocket, they no longer have to continue paying cost sharing. But Medicare has no such provision. Beneficiaries with complicated illnesses (and no Medigap protection) can end up owing tens of thousands of dollars towards the costs of Medicare covered services. This is particularly the case under Part B of the program where the 20 percent coinsurance can become quite large for those with extensive medical bills. Part B cost sharing constitutes about two-thirds of all Medicare cost sharing liabilities.

But combining A and B offers relatively few advantages for addressing these issues. It would make it easier, for example, to create a combined deductible. But that is not the main problem and in fact, many private insurance plans also have two deductibles. Moreover, that approach is problematic: To get a combined deductible that raises the same amount of contribution from beneficiaries would require a deductible of about $400. For those who are hospitalized in a given year, this would lower their cost sharing liability. But for the nearly 80 percent who do not go into the hospital, they would only see a rise in the deductible from $100 to $400. Such a large increase could be very unpopular with beneficiaries.

A better approach would be to lower the Part A deductible and eliminate both the spell of illness concept and the coinsurance for hospital stays. A relatively modest increase in the Part B deductible could offset much of those costs. Another important need is for a general upper bound on cost sharing, allowing at least some beneficiaries to forego purchasing private supplemental insurance.

Finally, one impact of a combined A/B Medicare program might reduce costs to beneficiaries. That is, if the Part B premium were to become a combined premium and linked as the Part B premium is now to the growth in costs of the benefits, the new premium would grow more slowly than under current law. This is because Part B is expected to grow more rapidly than Part A over time. For example, the Part B premium is expected to rise over time to about 11 percent of total Medicare spending, up from about 9 percent at present.

Making Medicare's cost sharing structure more rational and protecting those with the highest costs are important goals for Medicare reform. But it makes most sense to do this in the context of a broad range of changes rather than focusing just on a combined deductible.

Achieving Greater Efficiency in Program Management and Coordination. One need not look very far to

find critics of the Health Care Financing Administration and its management of Medicare. But the greatest problem here is lack of resources. Medicare's administrative costs of less than 2 percent are so low that *any* entity seeking to manage the program would be severely constrained. Even efficient private sector plans require a budget of three times that level -- or more -- in order to effectively oversee the complicated world of insurance. Only when there are sufficient resources will management improvements be possible. A considerable amount of flexibility and authority needs to be given to the management team to allow them to improve service both for beneficiaries and for providers of care.

Contractor reform is an essential piece of the changes that need to be made in Medicare. Medicare needs to contract with companies that are most skilled at claims processing, medical review and data collection and management. This may require a number of different contractors; consolidation is less important than competence and accountability. Again, a well managed organization can tolerate having a number of different entities as long as the lines of responsibility are clear and those contracted to do the job are skilled. The current system is a long way from there, but not because of carriers versus intermediaries. Rather the problem is that the government allows Blue Cross to nominate the intermediaries, restricts what HCFA can do in controlling these intermediaries, limits what types of organizations can contract to provide services both as carriers and intermediaries, and disallows contracts allowing for profits (hence excluding a number of potential participants). Efforts to achieve greater efficiency need to focus on these issues first, and the A/B split is only a small part of that issue.

Another important need for a well-functioning Medicare program is good coordination across different types of care for those who are still in traditional Medicare. Fee-for-service arrangements are inherently weak in providing incentives for coordination, but the track record of many HMOs where such coordination is supposed to be central leaves much to be desired as well. Consequently, the oversight of Medicare needs to focus on developing creative ways to bring coordination into the traditional program. This might be through disease management or case management models, for example. In those cases, a combined A/B structure makes sense, although this could be achieved via a de facto approach as well. That is, good data combining patient level information so that high cost cases can be identified and tracked can be done without a formal merger of the two parts of Medicare. HCFA already produces such data files, although more needs to be done in a timely way.

Medicare and Financing Issues. Critics of the current organization of Medicare often point out that much of the focus of attention is on Part A of the program. Its trust fund provides insights into the balance between the dedicated revenues from payroll taxes and elsewhere and spending on Part A services. That trust fund thus serves as an early warning signal of problems ahead and as a reminder that taxpayers have contributed over time more than enough to meet the needs of Part A. In the future, when Part A needs to draw on the trust fund balance to pay benefits, it will essentially be calling on the resources made available earlier. Any combination of A and B should keep these advantages.

The biggest danger with a combined approach is that a technical adjustment may be used as a back door means for dramatically changing the financing of the program. Both Parts A and B of Medicare need to be part of any consideration of financing issues. But formally combining A and B raises a number of complicated issues about how to view the financing of the program and how to think meaningfully about a trust fund structure. Financing issues are much broader than an A/B combination discussion; that discussion is essential to Medicare's future but ought to look broadly at where the resources should come from to support this important program.

The Bush Administration's efforts in this regard offer a troubling example of casually combining A and B. That is, the initial budget blueprint document submitted by the Administration treated Part B as if it were in deficit because it relies on general revenue financing. That is, it examined both A and B spending, but only part of the financing of the program when looking at Medicare's financial status. 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. This is implicitly scaling back the funding for Medicare below its current level. 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.

Part of the case made in the Bush document for combining A and B in examining Medicare was 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 and to that extent it could also be misinterpreted as improving financing. 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 nearly 11 percent when the phase in of home health is completed in 2004. Over the ten year period, that translates into 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.

Another claim that is often made about Medicare is that the growth in Part B, which has historically been higher than that for Part A, reflects problems with health care spending in Medicare. The growth over time between the two parts, however, represents a natural shift that has been occurring in health care for everyone. Surgery is more often done on an outpatient than an inpatient basis today, for example. More

procedures are undertaken in physicians' offices. The improvements in health care delivery that have allowed such changes reflect improvements that speed recovery and enhance the quality of life of beneficiaries. Without such a shift, Part A spending would have had to be much higher than it is today. Part B growth, thus, does not represent a failure in health care.

Both parts of Medicare should be considered with regard both to their spending *and* sources of income. In the Trustees' report each year, information on the combined share of GDP that Parts A and B are projected to need over time are provided. This is a reasonable starting place to examine the combined impact, although it understates Medicare's possible financing by showing costs on a pay-as-you-go basis. This allows no ability to build a reserve to smooth the impacts of the Baby Boomers' retirement or other demands, for example, as is the intent of the trust fund for Part A.

Should there be limits or constraints on general revenue contributions to Medicare? Even those who have implicitly argued for such a limit usually do not propose reducing general revenue contributions to zero. In a recent article, colleagues and I created an artificial trust fund for Parts A and B in which we examined the effects of one potential limit for general revenues. We assumed that the GDP share of general revenue going to Part B would remain constant. That provides one way to look at both A and B in a combined framework, again with no formal combination of the two. Interestingly, that approach indicated that, using the 2000 Trustees' report numbers, the date of exhaustion of the trust fund moves earlier by five years, but still well into the future. But even this analysis can miss the point: Medicare will need additional resources over the future to handle a doubling of the population served and a near doubling of the *share* of the U.S. population served by this program. Efficiency improvements and other changes in Medicare can help, but will not be sufficient to pay for another 36 million participants.

Both Parts A and B will need support. More willingness to raise revenues is needed to assure Medicare's future. And a direct discussion of how the shares should be broken out among payroll taxes, general revenues and beneficiary premiums needs to get underway. For example, it may be reasonable to obtain a disproportionate share of additional dollars from general revenues, which require people of all ages to pay and in a progressive manner.

Problems with Combining A and B

One of the chief concerns with combining Parts A and B of the program is how to treat those who enroll only in Part A and not B. When beneficiaries do so because they prefer their HMOs (in the case of FEHBP enrollees) or because they are still working, the federal government saves money by their choice to decline or defer the Part B subsidy. Special attention would need to be placed on how to treat these beneficiaries. As the number of older workers increase over time, this may become even more of an issue.

The other major problem has already been mentioned and that is the potential for effectively decreasing the funding for Medicare if proper attention to a stable base of support for Part B is not addressed in such a combination. Financing decision should not implicitly be made via technical adjustments.

In sum, Medicare's concerns go well beyond the issue of a program with multiple parts; the real concern needs to be ensuring that those parts are well coordinated, however organized, that resources are devoted to improving the way the program interacts with both beneficiaries and providers of care, and that the program is sufficiently financed to cover the care essential to this beneficiary population.

Summary of Main Points

Combining Parts A and B of Medicare will, at best, make only minor contributions to the improvements needed in the program. In fact, it is possible that too much attention on such a combination will deflect discussion on more critical issues.

Consider four goals often mentioned in this debate on combining A and B:

Simplifying the program. Medicare beneficiaries are often confused about the Medicare program, but the needs go well beyond understanding the two parts. Even a very complicated program can establish a single point of contact with well-informed workers helping Medicare beneficiaries with problems. It is the resources and commitment to improvement that need to go into the development of such a framework that matter.

Improving Cost Sharing. The combination of deductibles and coinsurance for Medicare represents an ad hoc collection of payments with little defensible justification as points of control for the use of health care services. But combining A and B offers relatively few advantages for addressing these issues. It would make it easier, for example, to create a combined deductible. But that is not the main problem and in fact, many private insurance plans also have two deductibles. Making Medicare's cost sharing structure more rational and protecting those with the highest costs are important goals for Medicare reform. But it makes most sense to do this in the context of a broad range of changes rather than focusing just on a combined deductible.

Achieving Greater Efficiency in Program Management and Coordination. One need not look very far to find critics of the Health Care Financing Administration and its management of Medicare. But the greatest problem is lack of resources. A considerable amount of flexibility and authority also needs to be given to the management team to allow them to improve service both for beneficiaries and for providers of care. Again, a well managed organization can tolerate having a number of different entities providing support as long as the lines of responsibility are clear and those contracted to do the job are skilled. The current system is a long way from there, but not because of carriers versus intermediaries.

Medicare and Financing Issues. Critics of the current organization of Medicare often point out that much of the focus of attention is on Part A of the program. The biggest danger with a combined approach is that a technical adjustment may be used as a back door means for dramatically changing the financing of the program. Both Parts A and B of Medicare need to be part of any consideration of financing issues. But formally combining them raises a number of complicated issues about how to view the financing of the program and how to think meaningfully about a trust fund structure. More willingness to raise revenues is needed to assure Medicare's future. And a direct discussion of how the shares should be broken out among payroll taxes, general revenues and beneficiary premiums needs to get underway.

Other Publications by the Authors

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