

Medicare: A Policy in Transition

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Since the beginning of the 20th Century, presidents and members of Congress have pressed for a health care policy that would cover all citizens. President Theodore Roosevelt argued that a nation had to have social insurance, including health insurance, to be strong because no country could lead the world if its people were sick and poor (Starr, p. 243). During the depression health insurance was second in priority, just behind unemployment compensation, for social insurance advocates. When Social Security was first considered, the inclusion of health insurance was a priority of some reformers. However, the American Medical Association (AMA) called a special session of its House of Delegates, which opposed compulsory health insurance but did accept a voluntary plan as long as it was controlled by the county medical associations and followed AMA guidelines. Fearing that the inclusion of health insurance would doom a Social Security bill, President Franklin D. Roosevelt recommended the bill without the health component, intending to seek it in separate legislation. Although the AMA offered some concessions, it strongly opposed any compulsory health insurance program and any program that would impact physicians' business by a financial intermediary. Franklin Roosevelt was reluctant to go up against the AMA but subsequently indicated that he would press for a health insurance bill following the war. After Roosevelt's death, President Harry Truman proposed a single payer health insurance plan (Starr, p. 281). In reaction, the AMA said that the Truman proposal would make doctors "slaves," though it would not affect the private practice of medicine. Arguments that it amounted to "socialized medicine" were regularly heard. Although the U.S. failed to extend government provided health insurance coverage, many Western European nations did; especially Britain, for example, that adopted the National Health Service in 1945.

President John Kennedy was a strong supporter of the adoption of a Medicare program, but it was not until the significant Democratic victory in the 1964 election that there was sufficient political support to pass a program. Enacted in 1965, Medicare covered those 65 and over, while Medicaid covered the poor. Neither act was very controversial at that time. When it began, Medicare had two parts: Part A covered hospital care, which was compulsory, and Part B covered outpatient services, including visits to doctors, which was voluntary. Both the voluntary nature of Part B and the basis of payment of services, customary and usual fees, were the result of pressure from the AMA. Today, Part B remains voluntary but because there is a financial advantage to join (and a penalty to delay joining after 65) enrollment is close to 100% of the eligible population.

Medicare Changes Since Its Adoption

The Medicare program, adopted in 1965, has undergone considerable change, responding both to financial pressures and changes in medical care. Of particular note is the basis that Medicare pays providers. In 1983 Medicare instituted a cost containment method in Part A for hospital care, wherein instead of essentially paying the billed amount, Medicare paid a specific reimbursement to hospitals based upon diagnosis, called "diagnostic related groups" (DRGs). This method of payment was intended to encourage hospitals to economize on the time that patients stayed in the hospital and reduce the number of in-patient days. Safeguards were instituted in an attempt to avoid hospitals releasing patients before they should be. However, the data show that admissions to hospitals were reduced, the average number of days spent in the hospital significantly declined, hospital censuses fell, and nursing home admissions of patients discharged from hospitals increased. It was said that hospital discharged patients "quicker and sicker." Nonetheless, the bundling of service did reduce costs. For Part B, the major reimbursement change was made in 1993, moving from customary and usual fees to a payment schedule for services, known as Resource Based Relative Value Scale (RBRVS). The declared purpose was not to reduce costs but to reallocate reimbursements, providing more for diagnostic services, such as provided by primary care physicians, and less for interventionist procedures, such as cataract surgery. The argument was that Medicare was paying too much for interventions but not enough for "contemplative" services.

A further Medicare change, pushed by Republicans, was the addition of the Medicare Advantage Plan, which is often called "private Medicare." In Medicare Advantage (earlier called Medicare + Choice), Part C of Medicare, patients can join an insurance program that bundles regular Medicare services with a supplemental Medicare policy. Instead of paying fee for service as in traditional Medicare, Medicare Advantage plans receive a fixed payment per enrollee, called capitation. These plans charge their enrollee a premium in addition to the capitation payment and often provide enhanced services to attract enrollees. In the 2000s, Medicare Advantage Plans, whose capitation was set at 95% of average cost of Medicare recipients in their region, argued that they were underfunded. Because of this, some had ended their plans. To rectify this, the Medicare Modernization Act in 2003 increased payments to Medicare Advantage Plans. However, it was soon discovered that the increase was too large. Overpayments are to be gradually reduced under the Patient Protection and Affordability Act of 2010. It is primarily in this area where funds from the claimed Medicare reduction of the Patient Protection and Affordability Act came. About 35% of Medicare beneficiaries are now receiving their services through a Medicare Advantage Plan. Fundamentally, Medicare Advantage was intended to rely upon managed care to reduce costs, be competitive, and be more efficient. Opposition contended that by introducing a separate plan, Medicare beneficiaries were divided into different plans, negating the ideas of Medicare being a single, national plan.

To save money in Medicare, Congress also enacted a payment formula, known as the sustainable growth rate (SGR) in the Balanced Budget Act of 1997 (BBA) (Patel and Rushefsky, 2006, p. 145; Hillman and Goldsmith, 2011, p. 90). However, when the formula was found to

reduce reimbursements, physicians and other affected groups (especially through the American Medical Association and state medical societies) put great pressure on members of Congress to eliminate the reduction. Congress consistently responded, negating the projected reductions for every year except 2002. Given the growth of the SGR based deficit, it is probable that the savings from the 1997 BBA will never occur (Hillman and Goldsmith, 2011, p.91). The expansion of expensive imaging services reduces the amount of funds available for physician services under the SGR formula.

The Medicare Modernization Act in 2003 introduced a drug benefit (Medicare Part D). In 1965 outpatient pharmaceuticals were not included in Medicare. Over the years, a limited number of drugs were covered, especially for kidney transplants. To rectify this deficiency, a drug benefit was added to be fully implemented in 2006. The benefit is offered through private insurance companies, some as a stand -alone benefit and some as part of a Medicare supplement policy. The consequence was that seniors were faced with choosing among many plans, each differently priced and covering different medication. The choice is critical to seniors for the failure to pick a plan that covered drugs they were taking would result in large out of pocket expenditures. The drug plans also included a so-called "doughnut hole," the dollar amount that the plans would not cover before they then picked up 95% of the costs. This has become a major problem to a number of seniors. The Patient Protection and Affordability Act addresses this, gradually closing the doughnut hole.

Taxes and premiums for Medicare have changed several times as well. When Medicare began, its payroll tax for Part A was limited to the same income ceiling as Social Security. With the increased cost of Medicare, the income ceiling for that program was pegged at an earnings level higher than Social Security and ultimately the ceiling was eliminated. Now the full earned income is subject to the Medicare payroll tax. In 1997, the payment from general taxes for Medicare Part B was fixed at three-quarters of the cost of the program, where previously it had fluctuated based upon a formula. Also in Part B an increased premium for higher earners was adopted as part of the 2003 Medicare Modernization Act. A similar income based provision will be added to Part A in 2013, levying an additional .9 percent for earnings over \$200,000 for individual filers and \$250,000 for joint tax payers. The additional premium, together with other Medicare changes, is estimated by the CBO to extend the life of Medicare 10 years beyond the previous estimate for Part A trust fund.

Problems Confronting Medicare

Of all problems, demographic change is paramount. Individuals are living longer and therefore beneficiaries are receiving medical care for more years than decades ago. Now surviving or avoiding illnesses with high mortality rates, beneficiaries live long enough to encounter diseases that in prior generations they would not have experienced. Many of these conditions, such as Alzheimer's disease, are expensive to treat and care for and provide very complicated care situations since these seniors have multiple conditions. Conditions that at one time where there was little medical treatment available are now being routinely addressed. Heart disease, which once had a high mortality rate with treatment mostly restricted to hospital

stays on oxygen supplement with a few medications, are now treated with an armory of drugs, cardiac artery stenting, and cardiac bypass surgery. Cancer, once a death sentence, is now treated in an increasing number of cases as a chronic condition. The consequence for Medicare is that it is insuring patients at much more medically expensive phases of their lives. This is especially true in the last months of their lives, where medicine addresses their conditions with sophisticated and often expensive modalities. Palliative care, hospices, living wills, and durable power of attorney are available, but many patients and their families have hope and want their relatives given all treatments. For Medicare the consequence is an escalation of costs.

Demographically we are also beginning to see an increased eligibility for Medicare as the baby boom generation reaches 65. Sharing the problem with Social Security, Medicare is seeing a significantly reduced ratio of working individuals to those retired and eligible for Medicare benefits. Unlike nations with a very young population, the U.S. shares with other countries, such as Japan, a shrinking ratio between those working and those retired. It should be noted that the ratio issue affects Medicare Part A, hospital care, and not Part B. Only beneficiaries pay into Part B. The payroll tax is specific to Part A. This is critical to understanding that Medicare's so-called solvency problem relates only to Part A, which must pay all his benefits from its trust fund.

The rapid inflation in health care costs is also affecting Medicare. U.S. health care costs, the most expensive in the world, increase at rates exceeding inflation every year and in most years are greater than the increase in Gross Domestic Product (GDP), resulting in a rising percent of GDP being devoted to health care. It should be noted that studies have shown that U.S. residents get neither more nor better health care than many countries around the world, but health care provided is clearly more expensive in the U.S. (Nolte and McKee, 2008). Cost increases affect everyone, but also impact Medicare. Although Medicare does pay less than private insurers for services, Medicare payments cannot drop too low because providers will refuse to see Medicare patients as many do for Medicaid patients. Although some claim that this has already occurred (e.g. with concierge practices), data show that provider refusal to see Medicare patients remains small.

Technological changes have ratcheted up costs in Medicare as well as in private insurance. Unlike some fields where technological change reduces costs, in medicine, it more typically increases costs. MRIs, CT scans, and PET scans, among others, have escalated imaging costs, which at one time were mostly plain x-rays. (Hillman and Goldsmith, 2011) New surgical procedures, medical devices such as artificial joints, and biotech drugs have proved to be major cost drivers. Cost containment measures can help, but they can go only so far at keeping costs down. Efforts such as reducing multiple CT scans in the same day, overuse of spinal fusion, and use of unproven surgeries can provide some cost reduction but this is only the tip of the cost iceberg. The Patient Protection and Affordability Act does develop a new committee to examine the efficacy of medical practices, but unlike the National Institute for Health and Clinical Excellence (NICE) in Great Britain, it is prohibited from rationing and can only make recommendations.

Fraud and abuse weigh heavily on Medicare. Reports from a number of national organizations maintain that a significant percentage of bills for Medicare reimbursement are fraudulent. Considerable effort has gone into reducing this. The Obama administration arrested a record number of individuals in one sweep. All reform proposals include capturing dollars from fraudulent expenditures, but to do so requires difficult investigatory work. Data-mining computer technology has helped, but it is still difficult.

Financial Projections for Medicare

In Medicare, the greatest financial concern is Part A, Hospital Care, because its expenditures are restricted to HI Trust Fund money, including sums from the payroll tax and interest on federal bonds that the Trust Fund holds. Although increased medical expenses for Part B, outpatient care (including medical tests), are clearly a problem, there is not a solvency issue because 75% of the costs are required to be funded from general taxes, premiums, and interest on bonds. Thus, increased cost trigger required increased premiums. The so-called "doc fix" raises the cost of Part B, but does not affect Part A. Recently Part B saw smaller premiums than necessary paid because the Social Security law limits premium increases to increases in Social Security benefits. Given that Social Security beneficiaries saw no Cost of Living (COLA) increase in December 2009 and 2010, premium increases for Part B were restricted to new enrollees. Thus the 2009 premium of \$96.40 remains in force in contrast to \$115.40 for new beneficiaries, constituting 25 percent of the total. Beneficiaries with incomes greater than \$85,000 and \$170,000 for joint income tax filers pay more per month with amounts ranging from \$161.50 to \$369.10 per month in 2011 (2011 Annual Social Security Report).

For Part A, Hospital Insurance (HI), the 2011 Annual Social Security Report shows the beginning of the drawdown of the surplus in the HI Trust Fund. Because of the weak economy, contributions to the fund are lower (fewer people working) and more payouts (more people relying on Medicare than their employer sponsored insurance), the fund is projected to be exhausted by 2024, five years earlier than it had been estimated in the 2010 Annual Social Security Report. However, it should be noted that payment for hospital expenditures would not cease because it *will still be able to pay 90% of hospital costs* even if no additional reform is made to the system. Projections show this, declining to 75% by 2045 and then, interestingly, increasing to 88 percent in 2085. Thus to say that HI will be "broke" is more rhetoric than reality. Medicare could manage the reduced percentage by stretching out payments (2011 Annual Social Security Report).

For Part B, although the solvency concern is not an issue, there is the worry that it provides an increased drain on the Treasury because general taxes pick up three-quarters of the cost. Thus the combined drawdown in HI, where the Treasury must sell bonds to the public or increase taxes to pay off the HI Trust fund bonds, and the increased direct cost of Part B result in a major impact on the federal budget. As a consequence, reform is warranted. It should again be stressed that this would not be the first time that Medicare has been changed since its introduction in 1965. Both its revenue stream and payment methods have been modified.

Reform Proposals

There are many potential changes that would assist Medicare's financial viability, some amounting to incremental change and others more radical. It is likely that some combination of reform options will ultimately be enacted, more in line with several smaller changes that have occurred in the past than major restructuring. Medicare is highly popular and radical change can be pushed only at the political peril of its supporters. Although this paper will focus on Medicare options, it should be noted reforms that reduce health care costs in general would help both Medicare and non-Medicare health care recipients as well as the macroeconomic environment.

1. **Increase the Medicare Age to 67 from 65.** This reform is logical in that the Social Security age of full benefits is gradually increasing from 65 to 67. However, given that U.S. policy is aimed at having more residents insured, increasing the age to 67 would be moving in the opposite direction. With Social Security's full benefits age increasing and people living longer, one could argue that employees should simply work longer, receiving their employer sponsored health insurance, which may be more readily available under the Patient Affordability and Protection Act. But critics have noted that while this may be possible for white collar workers, manual laborers may find it physically impossible to work to 67.

Raising the age to 67 is projected to reduce Medicare spending (estimated at \$7.6 billion in 2014), but would also reduce premiums going to Part B (\$7 billion). However, all the cost savings would not be realized because expanded coverage under Medicaid would increase (\$8.9 billion), affecting both the national and state governments, and additional federal cost for insurance subsidies under the Exchange as provided by the 2010 health reform law (\$7.5 billion). Further, employers would pay more as individuals who would have become eligible elect to stay employed or as retirees and on their employer sponsored plan. (\$4.5 billion) Those who seek insurance from the Exchanges would pay more in premiums and cost sharing under the new arrangement. Overall, the forecast is that 42% would elect their employers sponsored plan, 38% would enroll in the Exchanges, and 20% would be covered under Medicare (Neuman, Cubanski, and Waldo, 2011).

2. **Increase Medicare Taxes and Premiums.** The Medicare Payroll tax percentage can be increased as well as the premium for Part B. Some have suggested that tax increases be limited to higher income individuals by either increasing the percent that they pay or their premium. Given that this is in the law now, it would be a small move to increase rates. Rather than increased rates, some have recommended that the Medicare tax be paid on unearned income, such as dividends and capital gains. Some wealthy earners pay little Medicare taxes because most of their money comes through non-earned income. Support would be based upon the "ability to pay" principle. Opposition would

be similar to opposition to any tax increase, which could include the argument that there would be less income to invest which may go to create jobs.

3. **Changes In Reimbursement Methods.** There are multiple possibilities here that would contain costs, including paying physicians to treat an illness rather than fee for service, where there is an incentive to increase services. Incentives need to be provided to hospitals to reduce costs, including reducing hospital acquired infection rates and errors that extend patient stays. It should be noted that the largest health care expenditure is for hospitals. States could again be mandated to institute certificate of need laws and rate review commissions. Wisconsin had both at one time that restrained costs, but both were not renewed by the legislature, resulting in the escalation of health costs in the state.
4. **Remove Physician Training Cost from Medicare.** The federal government essentially helps hospitals support physician residency programs by paying a higher reimbursement rate to cover these costs. Some analysts claim that this has also provided an incentive to increase specialty residency slots over primary care training. Nonetheless, many health care policy analysts have recommended that financial support for training should be separate from Medicare.
5. **Increase deductible and co-payments.** Medicare can increase the deduction that beneficiaries or their supplemental insurer pays for both hospital stay and outpatient services. The 2011 hospital deductible is \$1,132 and outpatient deductible is \$162. As for co-payments, Medicare now pays 80% of approved charges in Part B and does not have a co-payment until an individual is in the hospital greater than 60 days. For outpatient services, the percentage paid by Medicare could be reduced to 75%. One limitation in doing this is that the Patient Affordability and Protection Act, which adds preventive services to Medicare, requires that these preventive services not have co-payments. The other problem is that if supplemental insurance will cover the additional expenses not paid for by Medicare, then the cost of that insurance will rise.
6. **Voucher Plan (called premium support by Rep. Paul Ryan).** This option has been periodically suggested to replace Medicare. It would substitute private insurance for individuals now under 55 years old for Medicare's single payer plan. Essentially, it transforms a defined benefits system to a defined contribution system. Government would not be held responsible for medical expenditure increases because it would set specific amount that individuals would get to purchase private plans. The one exception would be for lower income individuals, who would get a bit more to purchase private health insurance. Such a plan would specify the benefits and the specific costs that insurance policies would be required to include. This plan is somewhat similar to the current Medicare Part C, Medicare Advantage Plan, but with a lower level of government funding and fewer defined services covered. Specifically
 - Individuals 65 and younger disabled individuals will only have the option of obtaining private insurance in 2022 (i.e. those now under 55).

- Government makes payments directly to private plans
- Government payment adjusted for health status--average estimate \$8,000 in 2022 or 39% of projected Medicare spending per beneficiary.
- Premiums can't vary by health status but can increase by age. Older beneficiaries would pay more (CBO, 2011).
- Higher income Medicare beneficiaries would get less--70% reduction for top 2% of income distribution and 50% for next 6% of income distribution
- CBO (2011) estimates that beneficiaries would have to pay an average \$12,500 out of cost versus \$5,630 under current Medicare. Under Ryan's plan typical 65 yr. old Social Security beneficiaries in 2022 would pay 50% of their Social Security benefits in out of pocket medical expenses. (Those receiving payments at an earlier age would pay a greater percent).
- Payments would rise based upon Consumer Price Index (CPI-U), which has been lower than medical cost inflation (CPI-Medical) or Medicare spending.
- Elimination of Medicare Part D as a separate program.
- Return the prescription drug doughnut hole scheduled to be eliminated under the Patient Affordability and Protection Act.
- Eliminate Independent Payment Advisory Board intended to recommend Medicare spending reductions under the Patient Protection Act
- Eliminate voluntary Community Living Assistance Services and Supports (CLASS) long term care insurance supplement authorized under the Patient Affordability and Protection Act.
- Raise eligibility for Medicare beginning in 2022 from 65 to 67.
- Does not include support for Medicare Education and rural health care as existing Medicare program does.
- Lower-income beneficiaries would have a subsidy deposited in a Medical Savings Account (MSA) for them. Amount would increase by CPI-U. Amount estimated at \$7,800 is short of the \$12,500 CBO estimates as average out of pocket costs.

Arguments in favor of the plan are that it would limit government costs and provide an environment for plans to compete for policy holders on the basis of price, quality, and service (Fuchs and Potetz, 2011, p. 2). Government costs could increase if it becomes necessary to raise the subsidy to attract private plans to participate as occurred with Medicare Advantage plans. Private insurers will impose greater utilization controls than currently with Medicare (Fuchs and Potetz, 2011, p. 6).

The most significant problem cited for the plan is that it would cost seniors considerable more. The amount suggested for premium support, around \$6,000- \$8,000 a year, is insufficient to cover the cost of private insurance. In addition to Medicare taxes and premiums, seniors would have to pay an additional \$12,500 a year in additional expenses including premiums. Older seniors will pay more for premiums with no limit specified in Ryan's

plan. It is possible that costs could result in some seniors becoming uninsured (Fuchs and Poetetz, 2011, p. 14). A second major issue is that private insurance has significantly greater administrative and marketing costs than Medicare. Further, private insurers, representing a smaller percent of the market, will have less leverage over providers to contain costs. Currently, private insurers pay more for services than Medicare. Without a doubt medical cost for seniors will increase. However, government would be able to save money by paying a fixed sum and shifting costs to seniors. Further, although "a standard for benefits" would be established by the Office of Personnel Management (OPM), based upon current practice by OPM they would require plans to include benefits to cover certain costs but would not specify a defined set of benefits as the current program does (Kaiser, April 2011). Thus it is possible that plans could design a benefit structure that could discourage sick people from enrolling (Fuchs and Potetz, 2011, p. 8).

In conclusion, there are multiple possible options to improving the financial position of Medicare. Without any change, it will still be able to pay 90% of its costs. Policy changes present not only a technical problem in analysis and trade-off, but a political situation in changing a very popular program. It is doubtful that today's super-partisan Congress will be able to agree on reforms.

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