

Report for Congress

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Medicare Structural Reform: Background and Options

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Summary

Medicare is a nationwide health insurance program for the aged and certain disabled persons. Over its nearly 37-year history, it has provided important protections for millions of Americans. However, the program is facing a number of problems. One concern is that Medicare's financing mechanisms will be unable to sustain it in the long run. Many are also concerned that the program's structure, which in large measure reflects both the health care delivery system as well as political considerations in effect at the time of enactment, has failed to keep pace with the changes in the health care system as a whole.

The major problems facing Medicare, and possible solutions to these problems, have been debated for a number of years. Some persons suggest that major structural reforms are required. However, others contend that the existing system should be improved rather than replaced. To date, no consensus has been reached. In recent years, the major focus has been on providing prescription drug coverage for beneficiaries. Some observers state that it would be inappropriate to add a new costly benefit before structural reforms are enacted. Other observers state that seniors, particularly low-income seniors, should not be required to wait for benefits until resolution of the entire restructuring issue.

The 108th Congress is expected to consider a variety of Medicare reform proposals. Some changes could be made while still retaining Medicare's current structure. Examples include increasing the program's eligibility age, introducing means testing, increasing beneficiary cost-sharing, and introducing innovations into the current fee-for-service program. Other changes could only be made in the context of major program restructuring. Proposals which have been suggested include modernizing the benefit structure and combining the Part A and Part B programs. Also receiving attention are variations of a premium support model under which beneficiaries would be entitled to a specified level of financial support toward the costs of Medicare covered services. Many of the proposals could be combined as part of an overall reform package that would include prescription drug coverage. The Congress may also review the operations of the agency that administers Medicare and could consider restructuring that agency. This report will be updated to reflect legislative activity.

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Medicare Structural Reform: Background and Options

Overview

Medicare is a nationwide health insurance program for the aged and certain disabled persons. Over its nearly 37-year history, it has provided important protections for millions of Americans. However, the program is facing a number of problems. One concern is that Medicare's financing mechanism will be unable to sustain it in the long run. Many are also concerned that the program's structure, which in large measure reflects both the health care delivery system as well as political considerations in effect at the time of enactment, has failed to keep pace with the changes in the health care system as a whole. A related concern is whether the program's benefit structure adequately responds to the health care needs of today's aged and disabled populations.

A number of observers have stated that the program is now at a critical juncture. Some persons suggest that major structural reforms are required. However, others contend that the existing system should be improved rather than revamped. The following is a brief overview of the major issues underlying the debate. These issues are discussed in more detail in subsequent sections of the report.

Medicare and the Federal Budget

Medicare is the nation's second largest social welfare program, exceeded only by Social Security. It is an *open-ended entitlement program* that provides coverage for a *defined package of services*. Medicare is a *mandatory spending program*; it pays for as many covered medical services as the eligible population uses. As a result, it is difficult to control overall program spending.

Medicare is a key concern for policymakers, not only because of its role in financing health care for the elderly, but also because it represents a major spending item in the federal budget. Net program outlays (after deduction of beneficiary premiums) will represent an estimated *11.4% of total federal outlays* (\$237 billion) in FY 2003 and are expected to reach *14.9% of total federal outlays* (\$431.7 billion) by 2012.

Medicare Financing

Solvency. Medicare is actually two programs – Medicare Part A and Medicare Part B. Each program has a different financing mechanism. Medicare Part A is primarily financed by *current workers and their employers* through a payroll tax.

Medicare Part B (Supplementary Medical Insurance (SMI)) is financed by a combination of monthly premiums levied on *current beneficiaries* and federal general revenues (tax dollars).

Because of its financing mechanism, Part A has been subject to considerable scrutiny. Almost from its beginning, the program has faced a projected shortfall. At the present time, income to the Part A Hospital Insurance (HI) trust fund exceeds benefit payments and administrative costs. However, this situation is slated to reverse in the future with outgo exceeding income. At some point, the assets in the program will be insufficient to pay benefits. Under current projections, the first year that outgo will exceed income (excluding interest) is 2016 and the year the program will become insolvent is 2030. These dates represent a significant improvement over projections made only a few years earlier and reflect the impact of legislative changes which had the effect of restraining the growth in Part A spending. Despite the short term improvements, the long range deficit is significant. The long-range projections reflect a number of factors including an increase in medical care costs, the increase in size of the Medicare population with the retirement of the baby boomers, and a reduction in the ratio of workers paying the payroll tax (which finances the Part A program) to beneficiaries receiving benefits.

Many observers contend that it is no longer appropriate to view the Part A and Part B programs separately. Part B does not face exhaustion because of the way it is financed. However, projected spending growth in both programs is viewed as unsustainable over time. Many persons suggest that a comprehensive approach is required both to address the program's financing issues and to bring the program's benefit structure into the 21st century.

Current Issues. Recently, considerable attention has been focused on the Medicare Part A "surplus." As noted, income to the HI trust fund during a year currently exceeds outgo during the year. Some persons have labeled the difference between HI income and outgo as a "surplus." Any excess in a year is treated as part of the overall "on budget" surplus (unlike the Social Security surplus which is off budget). Some persons are concerned that the temporary Medicare surplus will be used either for other government spending or to finance a new drug benefit, thereby shortening the time before the program becomes insolvent. However, others suggest that using the "surplus" for the Medicare population, for example to finance a new drug benefit, might be appropriate.

Benefit Structure

Medicare's benefit design has remained relatively unchanged since enactment of the program in 1966. Many persons view this time as an opportunity to reexamine the structure as well as the financing of the program. Several key components of the current system are being reexamined.

Coverage Gaps. While Medicare provides broad protection against the costs of many, primarily acute care, services, it only covers about one-half of beneficiaries' total health care bill. The program includes significant cost-sharing charges for most covered services, provides only limited protection for some other services (such as prescription drugs and nursing home care) and includes no protection against the

costs of some other services (such as hearing aids). Further, the program includes no upper limit (“catastrophic limit”) on cost-sharing charges.

Interaction With Other Coverage. Most individuals have some coverage in addition to basic Medicare benefits. Many observers have suggested that when reviewing Medicare’s coverage, it is important to understand the interaction of this supplementary coverage with Medicare. This is not an easy task, since there is wide variation among plans in the services covered and total costs to beneficiaries. Further, there are indications that the scope of supplementary coverage available to some persons may be eroding.

Low-Income. Of particular concern to policymakers is the impact of out-of-pocket health spending on low-income persons without supplementary insurance protection. This population group is generally viewed as being the most at risk for health costs not covered by Medicare.

Benefit Design. Currently Medicare guarantees beneficiaries coverage for a *defined set of benefits*. Some observers have suggested that the concept of a defined package of Medicare benefits should be reexamined. They suggest that the program should use a *defined contribution* model under which the federal government would guarantee a defined payment per beneficiary. A variation on this approach is known as the *premium support* model. Under premium support, payment would be made to private health care plans for a portion of the premiums charged by the plans for covered Medicare benefits.

Beneficiary Perceptions and Concerns. Medicare provides millions of senior citizens and disabled persons with significant protection against the costs of their health care. Beneficiaries value the program and register strong opposition when policymakers suggest reducing the benefits or increasing the program’s premiums or cost-sharing charges. The ability of beneficiaries to shoulder additional costs is of concern, particularly in light of the fact that most beneficiaries have relatively modest incomes. For example, 65% of the Medicare population had incomes below \$25,000 in 2000.

Program Administration

For some time, observers have expressed concern over the way in which Medicare has been administered. Some persons believe that the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), has not been provided with sufficient resources, both staff and funding, or management flexibility to enable it to carry out its ever increasing responsibilities. Others believe it is time to restructure Medicare’s administrative entity – either by separating Medicare administration from the oversight of Medicaid and other state-based health programs or, alternatively, creating a separate entity to administer Medicare’s managed care program and any new prescription drug benefit. This last view may have been partially addressed by the 2001 administrative reorganization of HCFA into CMS with its three major divisions: the Center for Medicare Management responsible for Medicare’s fee-for-service program; the Center for Beneficiary Choices responsible for beneficiary education, the Medicare +Choice

program, and grievance and appeals; and the Center for Medicaid and State Operations responsible for programs administered by the states.

Current Reform Discussion

The major problems facing Medicare, and possible solutions to these problems, have been debated for a number of years. However, to date, no consensus has been reached. In recent years, the major focus has been on providing prescription drug coverage for beneficiaries. However, some observers have suggested that it would be inappropriate to add a new costly benefit before the financial soundness of the basic program is assured. They also suggest that drug coverage should not be added until the whole benefit structure is reexamined. Other observers have stated that seniors, particularly low-income seniors, need a drug benefit. They contend that these persons should not be required to wait for drug benefits until resolution of the entire restructuring issue. Further, some of these persons argue that while the program needs improvements, major structural reforms are not required.

A number of these concerns were addressed by the National Bipartisan Commission on the Future of Medicare (hereinafter referred to as the Medicare Commission). This Commission, established by the Balanced Budget Act of 1997 (BBA, P.L. 105-33), was to develop recommendations concerning a number of program issues. The recommendations were to be submitted to the Congress by March 1, 1999. The Commission failed to get the required 11 of 17 Commissioners' votes for a reform proposal. However, the "Breux-Thomas proposal" (named after Senator Breux and Congressman Thomas, the two chairmen of the Commission) gained 10 votes. This plan, which was based on the premium support model, served as the basis for subsequent discussion of the issues. A modification of this proposal was introduced in the 106th Congress (S.1895); this was known as "Breux-Frist 1" (after Senators Breux and Frist). A revised version, which focused primarily on drug coverage and some managed care reforms, was also introduced several months later (S.2807); this was known as "Breux-Frist 2". Slightly revised versions of these bills were introduced in the 107th Congress (S.357, the Medicare Preservation and Improvement Act of 2001, and S.358, the Medicare Prescription Drug and Modernization Act of 2001). They were also referred to as "Breux-Frist 1" and "Breux-Frist 2."

The primary focus of the discussion in the 107th Congress was on prescription drug coverage. Additionally, the 107th Congress considered, but was also not able to reach agreement on other Medicare issues, such as addressing declining enrollment in the M+C program and reduced payments for physician services. The House passed H.R. 4954, on June 28, 2002, legislation that included a prescription drug benefit, and other major changes to the Medicare program, such as Medicare+Choice program and provider payments. The Senate considered, but did not pass, S. 2729, (the "Tripartisan" bill) that would have added a prescription drug benefit, restructured Medicare cost sharing, and changed the program administration.

Background on the Medicare Program

Medicare is a nationwide health insurance program. In FY2003, the program will cover an estimated 34 million aged persons and an additional 6 million disabled individuals. CBO's March 2002 baseline estimates total program outlays in FY2003 at \$264.8 billion; net Medicare outlays (after deduction of beneficiary premiums) are estimated at \$237 billion. Medicare actually consists of two distinct parts — Part A (HI) and Part B (Supplementary Medical Insurance, SMI).

Coverage

Medicare is *not* a means tested program; that is, there are *no income or assets tests* for coverage. Almost all persons over age 65 are automatically entitled to Medicare Part A. Part A also provides coverage, after a 24-month waiting period, for persons under age 65 receiving social security cash benefits on the basis of disability. Most persons who need a kidney transplant or renal dialysis are also covered, regardless of age.

Participation in Medicare Part B is voluntary. All persons over 65 and all those enrolled in Part A may enroll in Part B by paying a monthly premium (\$58.70 in 2003). Most persons eligible to enroll in Part B do so.

Benefits

Covered Services. The Part A program covers the following services:

- *Inpatient Hospital Services* – Days 1-60 in a benefit period¹ are subject to a deductible (\$840 in 2003). Days 61-90 in a benefit period are subject to a daily coinsurance charge (\$210 in 2003). Beneficiaries have 60 lifetime reserve days which may be drawn upon for stays in excess of 90 days; these lifetime reserve days are subject to a daily coinsurance charge (\$420 in 2003).
- *Skilled Nursing Facility (SNF) Services* – Up to 100 days post-hospital care in a benefit period. Days 21-100 are subject to a daily coinsurance charge (\$105 in 2003)
- *Home Health Care* – No cost-sharing is required
- *Hospice Care* (home care services for the terminally ill). Nominal copayments are charged for outpatient prescription drugs and respite care.

Part B covers physicians services, laboratory services, durable medical equipment, other medical services, as well as a portion of home health expenses. In general, beneficiaries are liable for a \$100 deductible. The program then pays 80% of Medicare's recognized payment amount, while the beneficiary is liable for the

¹ A benefit period begins when a person enters a hospital or skilled nursing facility and ends when the individual has not received hospital or skilled nursing care for 60 days in a row. An individual can have an unlimited number of benefit periods.

remaining 20%. Beneficiary cost sharing does not apply to clinical laboratory services, certain preventive services, and home health care.

Payments for Services. Under “original” or “fee-for-service” (FFS) Medicare, beneficiaries obtain services from providers of their choice. Medicare’s payment policies determine the amounts that providers will be paid for covered services and supplies used by the beneficiaries. These payment policies have moved away from paying fees for each service rendered and basing this reimbursement on allowable costs or allowable charges. Instead, Medicare uses different rate setting methods for each provider type or category of service to determine payment amounts. Depending upon the setting, services can be bundled together; most payment amounts are *predetermined* in that they are set in advance; many are subject to certain limits; some are still partially determined by a provider’s incurred costs. Medicare’s current payment policies are myriad, complex, and often affected by past reimbursement practices. Simply put, Medicare does not negotiate prices or solicit bids to set competitively determined payments.

In general, Medicare uses either *prospective payment systems* or *fee schedules* to establish specific predetermined payment amounts for each service or bundle of services. Medicare adjusts these predetermined payments to account for factors, such as the relative costliness of patients, and practice location or cost of living differences that affect costs but cannot be controlled by the individual provider or supplier.

Under a prospective payment system (PPS), Medicare bases reimbursement on the average costs associated with an episode of care, regardless of the scope, type, and level of services provided to an individual patient. Medicare adopted the first PPS for inpatient hospital services in the early 1980s. In this PPS, hospitals are paid a standard amount or average cost for each discharge adjusted for a patient’s diagnosis (specifically, a patient’s diagnosis related group or DRG) as well as, for wage variations of a hospital’s geographic location, extent of physicians’ training programs, and amount of care provided to low-income patients (as a disproportionate share hospital). Most recently, Medicare has established prospective payment systems for skilled nursing facility services (SNF) services, home health services, and hospital outpatient services. The specifics of these payment policies, including the unit of payment and patient classification system that establishes the episode of care, vary by type of provider.

Medicare pays for a number of services under Part B using a fee schedule, including physician and laboratory services as well as durable medical equipment. Again the payments are determined in advance. However, the unit of payment tends to be narrower than the services that are bundled together and used as the basis of reimbursement in many of Medicare’s prospective payment systems. For example, under the physician fee schedule, a payment is made for each service provided during the office visit. In most cases, a physician can bill for more than one service provided during that office visit. The examples where services are bundled together and covered under one payment, such as a global fee which covers all physician services provided for a surgical procedure, are few.

Medicare+Choice. Since the early 1980s, Medicare beneficiaries have been able to enroll in some type of managed care plan, most commonly health

maintenance organizations (HMOs). Beneficiaries get all of their Medicare services through the HMO. The HMO agrees to assume the risk for paying for covered services; in return, Medicare makes a predetermined monthly payment to the plan for each enrollee.

The Balanced Budget Act of 1997 (BBA, P.L.105-33) established the Medicare+Choice program. This program, which became effective January 1, 1999, expanded the types of managed care arrangements that could potentially serve Medicare beneficiaries to include, among others, private fee-for-service organizations, preferred provider organizations, and provider sponsored organizations. However, HMOs remain the primary managed care arrangement available to Medicare beneficiaries. As of December, 2002, less than 13% of the Medicare population obtained services through Medicare+Choice plans.

Traditionally, Medicare payments to HMOs varied considerably throughout the country. In areas where payment rates were high (for example, Southern Florida), HMOs were typically able (and were often required) to offer services in addition to those covered under the basic Medicare program. Of particular importance was the ability of a number of plans to offer prescription drug coverage at little or no additional cost to beneficiaries. Conversely, in lower payment areas (for example Minneapolis-St. Paul metro area), plans typically did not offer a similar scope of additional benefits. If they did cover extra benefits, they charged the beneficiary a premium (which was in addition to the Part B premium which all enrollees are required to pay).

BBA significantly modified the payment methodology beginning January 1, 1998. The changes were designed to reduce the wide variation in payments and the year-to-year volatility that resulted from the old payment rules, especially in less populated counties. As a result, capitation payments in many previously high payment areas are seeing relatively small year-to-year increases. The managed care industry has argued that the changes in payment policies have resulted in inadequate reimbursement rates. However, reviews by both the General Accounting Office (GAO)² and the Inspector General of the Department of Health and Human Services (HHS)³ suggest that the payments are still adequate to cover the costs of *Medicare covered benefits*. In many cases, the issue is whether plans can continue to offer a range of extra services at relatively low cost to beneficiaries. Many plans question whether they can continue to be competitive if they drop prescription drug coverage or, alternatively, institute significant cost-sharing requirements for the coverage. These concerns, coupled with other business considerations, led a number of Medicare+Choice organizations to reduce their service areas or pull out of the

² U.S. General Accounting Office. *Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings*. GAO/HEHS-00-183. September 2000.

³ U.S. Department of Health and Human Services. Office of Inspector General. *Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997*. Memorandum to HCFA Administrator, A-14-00-00212. September 18, 2000.

program entirely.⁴ In response to these concerns, the Balanced Budget Refinement Act of 1999 (BBRA, P.L.106-113) and the Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (BIPA, P.L.106-554) included provisions designed to encourage organizations to participate in the Medicare+Choice program.

Administration

Since 1977, Medicare has been administered by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, within the Department of Health and Human Services. CMS is also responsible for overseeing Medicaid and the State Children's Health Insurance program, enforcing the Clinical Laboratory Improvement Act, and enforcing the Administrative Simplification and Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA). To perform these duties, CMS has about 4,500 full time employees, about 65% of whom work in the agency's headquarters offices in Baltimore, MD, and Washington, DC, with the remainder working in the agency's 10 regional offices around the country. In addition to the agency's federal workforce, CMS oversees about 47 claims processing contractors (generally private insurance companies) who employ an estimated 22,000 people to evaluate and pay Medicare claims. Other private and public sector employees – those who work for quality improvement organizations (QIOs - formerly known as peer review organizations) that determine the appropriateness of care in hospitals and other settings, private sector accrediting agencies (such as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO), or state survey agencies – also perform review, inspection, and evaluation functions to support the Medicare program.

Supplementary Coverage

Most beneficiaries depend on some form of private or public coverage to supplement their Medicare coverage. In the fall of 1999,⁵ about 12.5% of community-based (i.e., non-institutionalized) beneficiaries relied solely on the traditional fee-for-service Medicare program for protection against the costs of care; about 17% of beneficiaries were enrolled in managed care organizations.⁶ (The proportion enrolled in Medicare managed care has since dropped below 13%.)

⁴ For a further discussion of M+C see CRS Report RL30702, *Medicare+Choice*, by Hinda Ripps Chaikind and Madeleine Smith.

⁵ Some beneficiaries have supplemental protection throughout the year, while others may only have the protection for a portion of the year. Different studies rely on different measurements and therefore yield somewhat different data. The most recent study looks at beneficiaries' insurance status in the fall of 1999.

⁶ Data are from the Barrents group analysis of 1996-1999 Medicare Current Beneficiary Survey (MCBS). Beneficiaries were classified by their primary health insurance and were counted in only one of the following categories (in hierarchical order for beneficiaries with more than one type): Medicare HMO, Medicaid, employer-sponsored plan, Medigap, other public, and fee-for-service only. Laschober, Mary et. al. *Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999*. *Health Affairs*, Web Exclusive. February 27, 2002.

The majority of the community-based Medicare population (57.4% in the fall of 1999) have private supplemental coverage. This private insurance protection may be obtained through a current or former employer (33.1% had such coverage in the fall of 1999). It may also be obtained through an individually-purchased policy, commonly referred to as a “Medigap” policy (24.3% had these plans in the fall of 1999). In addition, a smaller percentage (about 10.9% in the fall of 1999) have coverage under Medicaid, the means tested federal-state health insurance program for the poor or persons who become poor after incurring large medical expenses. A small group (1.9% in the fall of 1999) have supplemental coverage from one of a variety of other sources (such as state-sponsored pharmacy assistance programs or through the Veterans Administration).⁷

Beneficiary Characteristics

Beneficiary Incomes. Most beneficiaries have relatively low incomes. In 2000, 5% of beneficiaries had incomes of \$5,000 or less, 20% had incomes between \$5,001 - \$10,000, 17% had incomes between \$10,001 and \$15,000, and 22% had incomes between \$15,001 and \$25,000. Twenty percent of the population had incomes between \$25,001 and \$40,000, while only 16% had incomes over \$40,000.⁸

Despite the relatively low average income levels, there has been a significant improvement in the poverty rate for the elderly. In 1970, 24.6% of the elderly population had incomes below poverty; in 2001 the figure had declined to 10.1%. However, the rate for children climbed slightly over the period (from 15.0% to 16.3%) and is now considerably above that for the elderly.⁹ These findings have raised questions regarding the appropriate use of limited resources available to assist persons across all age groups.

Beneficiary Spending. Most beneficiaries pay out-of-pocket for a portion of their health care expenses. These payments vary not only by the total level of an individual’s health care expenses, but also by whether or not the individual has supplementary coverage and what type of supplementary coverage the individual has.

Several studies have examined the level of out-of-pocket expenses and the relationship of these expenses to income. An analysis by researchers at the Urban Institute estimated that elderly beneficiaries would spend, on average, \$3,142 out-of-pocket for their health care in 2000. Of this amount, 20.9% was for Medicare cost-sharing charges, 20.5% for the Part B premium, 30.3% for non-Medicare services and 28.3% for premiums for supplemental health insurance. The authors estimated that out-of-pocket spending represented 21.7% of income for elderly beneficiaries; the percentage was significantly higher for those in poor health with no insurance

⁷ Ibid.

⁸ DHHS, Centers for Medicare and Medicaid Services. *Program Information on Medicare, Medicaid, SCHIP, and other Programs of the Centers for Medicare and Medicaid Services*, June 2002 edition.

⁹ U.S. Social Security Administration. *Annual Statistical Supplement, 2001*, and [<http://www.census.gov/hhes/poverty/poverty01/table1.pdf>].

(44.0%) and for older low-income single women in poor health (51.6%). The authors further projected that out-of pocket spending would increase rapidly over the following decade, in part because of the high growth rate for drug spending.¹⁰

A more recent study showed similar results. In 2002, the elderly's mean out-of-pocket spending is estimated at \$3,757 accounting for 22.3% of income. Medicare liability (Part B premium and cost-sharing) accounted for \$1,470 of the total.¹¹

Medicare Financing: Background and Issues

Financing Part A and Part B

The financing mechanisms for Part A and Part B are completely different. Part A is primarily financed by *current workers and their employers* through a payroll tax. Each pays a payroll tax of 1.45% on earnings. The self-employed pay 2.9%. Unlike Social Security (which in 2003 has a taxable earnings base of \$87,000), there is no upper limit on the amount of earnings subject to the tax. Part B is financed by a combination of monthly premiums levied on *current program beneficiaries* and *federal general revenues*. In 2003, the monthly premium is \$58.70. By law, beneficiary premiums equal 25% of Part B costs; federal general revenues (i.e., tax dollars) account for the remaining 75%.

Financial operations for Part A are accounted for through the Health Insurance (HI) trust fund while those for Part B are accounted for through the Supplementary Medical Insurance (SMI) trust fund. Both funds are maintained by the Department of the Treasury.¹² Each fund is overseen by a Board of Trustees who makes annual reports to Congress concerning their financial status.

Financial Status of Part A and Part B

Almost from its inception, the HI trust fund has faced a projected shortfall. When observers refer to the impending insolvency of Medicare they are actually referring to the pending insolvency of the HI trust fund. The SMI trust fund does not face exhaustion because of the way it is financed. However, the SMI trustees continue to voice concern about the rapid growth in Part B program costs.

Part A Projections. The Board of Trustees projected insolvency for the HI fund beginning with the 1970 report (which was less than 4 years after the program

¹⁰ Maxwell, Stephanie, Marilyn Moon, and Misha Segal. *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*. Commonwealth Fund, Urban Institute. January 2001.

¹¹ Maxwell, Stephanie, Matthew Storeygard and Marilyn Moon. *Modernizing Medicare Cost-Sharing: Policy Options and Impacts on Beneficiary and Program Expenditures*. The Commonwealth Fund, November 2002.

¹² The trust funds are an accounting mechanism; there is no actual transfer of money into and out of the fund.

went into effect). The insolvency date was postponed a number of times, primarily due to legislative changes which had the effect of restraining the growth in program spending. The lower growth rates were achieved largely through reductions in payments to providers, primarily hospitals and physicians. Generally, these measures were part of larger budget reconciliation laws which attempted to restrain overall federal spending.

Efforts to curtail program spending intensified as Congress considered legislation to bring the entire federal budget into balance and culminated in the passage of the BBA.¹³ This legislation achieved significant savings in Medicare and extended the solvency of the Part A trust fund. The legislation achieved these savings by again slowing the rate of growth in payments to providers and by establishing new payment methodologies for certain service categories. BBA also provided for the transfer of some home health spending from Part A to Part B. While the actual transfer from Part A did not reduce overall program spending, it did reduce Part A spending and thus delayed the Part A projected insolvency date.

A number of observers contended that the savings achieved through the enactment of BBA were greater than intended at the time of enactment and had unintended consequences for health care providers. As a result of these concerns, Congress subsequently enacted BBRA and BIPA. These measures were designed to restore some of the BBA spending reductions.¹⁴

Current Projections. In early 1997, the trustees projected that the Part A fund would become insolvent in 2001. Following enactment of BBA, significant improvements were recorded in the short-term projections. These new projections reflected a number of factors including BBA and strong economic growth. Despite enactment of both BBRA and BIPA, which increased program spending, the trustees have continued to delay the projected insolvency date. Most recently, the 2002 report projects that the program will remain solvent until 2030, 5 years later than projected in the 2000 report.

While short-term estimates have improved, the deficit is greater than previously thought for the long-range projection period. In large measure, this is attributable to a revision (beginning with the 2001 report) in the assumptions used to calculate expenditure growth.

¹³ For a history and summary of BBA see CRS Report 97-802, *Medicare Provisions of the Balanced Budget Act of 1997 (BBA, P.L. 105-33)*, by Jennifer O'Sullivan, Celinda Franco, Beth Fuchs, Bob Lyke, and Richard Price.

¹⁴ For a discussion of the BBRA and BIPA legislation as well as the Medicare cost estimates made subsequent to enactment of BBA, see: 1) CRS Report RS20484, *Trends in Medicare Spending: Fact Sheet*, by Hinda Ripps Chaikind; 2) CRS Report RL30860, *Medicare Provisions in the Balanced Budget Refinement Act of 1999 (P.L.106-113)*, by Carolyn Merck, Jennifer O'Sullivan, Madeleine Smith, and Sibyl Tilson; and 3) CRS Report RL30707, *Medicare Provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L.106-554)* by Hinda Ripps Chaikind, Sibyl Tilson, Jennifer O'Sullivan, Carolyn Merck, and Madeleine Smith.

The trustees state that to bring Part A into financial solvency over 75 years (CY2002-CY2076), either outlays would have to be reduced by 38% or total income increased by 60% (or some combination thereof) throughout the 75-year period. As noted, the primary income source for Part A is payroll taxes. Many observers oppose any increase in payroll taxes to support the program. They feel that current taxes already represent a considerable drain on the incomes of many middle class workers. They also suggest that merely increasing taxes would not address the program's inherent inefficiencies, including the inability of the program to constrain cost growth.

Demographic Considerations

The financing problems facing Medicare are expected to be magnified starting in 2011 when the program will begin to experience the impact of major demographic changes. First, baby boomers (those born between 1946 and 1964) begin turning age 65. Second, there is a shift in the number of workers paying the Medicare payroll tax and supporting those persons receiving benefits under Part A. Currently, there are approximately 4.0 workers per beneficiary; in 2010 there will be 3.7. By 2030 the ratio will have declined to 2.4.

Who Pays for Benefits

Another series of issues relates to who is, or should be, paying for covered benefits. Many beneficiaries feel that the combination of the payroll tax they paid during their working careers coupled with their Part B premiums represents full payment for their Medicare benefits. Various studies have shown that this is not the case. Most persons on Medicare today receive considerably more in Medicare benefits over their lifetimes than they pay in; this trend is expected to continue into future years for low and average wage earners; however, over time, high wage earners are expected to pay more into the system than they get back.

Under the current system, current workers pay a payroll tax to cover benefits for current Part A beneficiaries. Current workers also pay the majority of Part B costs since the federal government (i.e., current taxpayers) funds 75% of the costs of that program. These financing mechanisms have raised intergenerational equity issues. Many younger persons recognize that the program provides significant help to their parents and grandparents and has relieved them of some potential health-care expenses for family members. However, some younger individuals contend that they should not be required to assume a major portion of the costs for older populations. Many of these same individuals question whether Medicare will be there when they retire.

Medicare and the Federal Budget

Medicare is a key concern for policymakers, not only because of its role in financing health care for the elderly, but also because it represents a major spending item in the federal budget. The Congressional Budget Office (CBO) estimated total Medicare outlays for FY2003 at \$264.8 billion; net outlays (after deduction of beneficiary premiums) are estimated at \$237 billion. Net outlays represent an

estimated 11.4% of total federal outlays in FY2003. CBO projected the percentage would rise to 14.9% of total federal outlays by FY2012. CBO further estimated that total Medicare spending would represent 2.4% of the gross domestic product (GDP) in 2003, rising to 2.8% in 2012.¹⁵

Current Issues

HI “Surplus”. In general, income to the Hospital Insurance Trust fund during a year exceeds outgo during the year.¹⁶ Under current projections, the first year that outgo will exceed income, excluding interest, is 2016. The first year that outgo will exceed income, including interest, is 2022. Some persons have labeled the difference between HI income and outgo as a “surplus.” The trustees estimate that the total surplus would be \$453 billion over the FY 2002-FY 2011 period. In March 2002, CBO estimated the surplus at \$362 for the same period.

Any excess in a year is treated as part of the overall “on-budget” surplus (unlike the Social Security surplus which is off budget). Many persons are concerned that the temporary Medicare surplus would be used for other government spending rather than debt reduction. To counter this, some Members have recommended that the Medicare funds be placed in a “lockbox.” Under a lockbox proposal, a point of order could be raised on the House or Senate floor against any tax or spending legislation in a year that would reduce the on-budget surplus to less than the HI surplus receipts in that year.¹⁷

Some persons argue that the surplus represents Medicare money and therefore can be used for any Medicare-related purpose including a prescription drug benefit. Others argue that if surpluses from the trust fund are used for a new drug benefit or Medicare reform, the insolvency issues facing Medicare will occur much earlier than currently projected.

Status of Program as a Whole. A number of observers have suggested that it is inappropriate to view Medicare solvency only in terms of the Part A program. Rather, they suggest that the program should be viewed as a whole. For this reason, the trustees issued a combined report on Parts A and B in 2002. The trustees stated that meeting the financial challenges facing the two parts of Medicare would require integrated solutions. They also noted that the sooner solutions were enacted, the more flexible and gradual they could be. They further estimated that combined Part A and Part B expenditures are expected to rise from 2.4% of the gross domestic product (in 2001) to 5.0% in 2035 and 8.4% in 2075.¹⁸

¹⁵ Congressional Budget Office. *An Analysis of the President’s Budgetary Proposals for 2003*, March 2002 (Table 5: CBO’s Baseline Budget Projections), and accompanying Medicare tables.

¹⁶ Outgo exceeded income in 1995, 1996, and 1997.

¹⁷ See: CRS Report RS20165, *Social Security and Medicare “Lock Boxes”*, by David S. Koitz, Dawn Nuschler, and Geoffrey Kollmann.

¹⁸ Board of Trustees of the Federal Hospital Insurance Trust Fund. *2001 Annual Report of* (continued...)

Many observers have recommended using a comprehensive measure of Medicare solvency. Some have suggested that this should occur in conjunction with the merger of Part A and Part B into a single program. This issue is discussed further in a later chapter.

Other Major Issues

While program financing is of major concern to policymakers, it is only one of the issues facing Medicare. Other important issues include: whether the program has responded to changes in the health care delivery system, whether the benefit package adequately responds to the health care needs of aged and disabled beneficiaries, the role of supplementary insurance coverage, and whether the needs of the low-income are being addressed.

Response to Changes in the Health Care Delivery System

Many observers argue that the program's current structure, relying primarily on traditional fee-for-service mechanisms, has failed to adequately reflect changes that have occurred in the health care delivery system as a whole. While 90% of persons with employer-sponsored coverage are currently enrolled in some form of managed care, as of December 2002 under 13% of the Medicare population was enrolled in such arrangements. For the Medicare program, fee-for-service is expected to remain the program's predominant delivery system.

Medicare Benefits Package

Medicare provides broad protection against the costs of many, primarily acute care, services. However, beneficiaries are still faced with significant additional health care expenses. The program requires cost-sharing for most covered services, provides only limited protection for some services (such as outpatient prescription drugs and long-term care) and includes no protection against the costs of other services (such as hearing aids and dentures). Further, unlike most large group health insurance plans, Medicare contains no upper ("catastrophic") limit on out-of-pocket expenses. As a result, the program covers only about half of beneficiaries' total health bill.

Medicare's benefit package is somewhat less generous than typical employment-based coverage. It contains more generous coverage of mental illness and substance abuse than typical employment-based plans for the non-elderly. However, it lacks coverage for most outpatient prescription drugs, dental care, and a catastrophic limit on the amount of out-of-pocket expenses. These items are generally found in employment-based plans.

¹⁸ (...continued)

the Federal Hospital Insurance Trust Fund. Washington D.C. March 2001.

Many observers have recommended expansions in Medicare coverage. In recent years, the primary focus has been on prescription drugs. However, there is currently no consensus on how a drug benefit should be structured. One of the chief concerns is the potential cost of a new benefit and how these costs would be financed over time. There are also a number of organizational and administrative questions. These include whether a drug benefit should be enacted prior to or as part of overall structural reform; whether the new benefit should be part of the Medicare program itself or administered as a separate program; and the degree of reliance that should be placed on the private sector, both for administering the benefit and assuming a portion of the financial risk.¹⁹

Coverage of preventive services has also received attention in recent years. Initially, Medicare coverage was restricted to the diagnosis and treatment of illness or injury. Over time, coverage was added for some routine screening services. Recently, significant expansion in preventive services was included in the BBA and BIPA. Some persons have recommended additional expansions arguing that the provision of preventive care services actually results in savings over the long term.

Role of Supplemental Coverage

As noted earlier, most beneficiaries have coverage to supplement some of Medicare's coverage gaps. There is wide variation among beneficiaries in the types of coverage they have, the source of coverage, and depth of coverage. When considering Medicare restructuring proposals, it is important to remember that these proposals could have a very different impact depending on the type of supplemental coverage (if any) held by the beneficiary. It is also important to consider the implications of Medicare changes for other stakeholders providing this coverage such as managed care plans, private insurers, and state governments.

Managed Care Plans. As noted earlier, a number of Medicare+Choice organizations have reduced their service areas or dropped out of the program entirely. Other plans have reduced their coverage of extra services such as prescription drugs or increased the costs to beneficiaries for such services. As a result, many observers state that the current Medicare+Choice program requires reform. Many of the restructuring plans would incorporate a premium support or similar mechanism; this is intended to encourage a larger number of plans to participate in the program. (See discussion of premium support later in this report.) When reviewing various proposals it is important to consider what the impact will be on the actual number of plans willing to participate, the number of beneficiaries who will have a choice among plans, and the benefits these plans will offer.

It is also important to consider whether plans will be able to design their packages so that beneficiaries will be encouraged to enroll in a managed care arrangement. Beneficiaries are typically risk adverse. Therefore it could be expected that plans will need to be able to offer fairly broad coverage (including some

¹⁹ For a discussion of benefit design issues for prescription drugs, see: CRS Report RL31640, *Medicare Prescription Drug Coverage for Beneficiaries: Background and Issues*, by Jennifer O'Sullivan.

prescription drug coverage) with predictable (and affordable) premium and cost sharing charges. It will also be important for beneficiaries to know that the plans will continue to participate in the program over time.

Employer-Based Coverage. There are indications that the percentage of employers offering retiree health coverage for their Medicare-covered retirees is dropping. In addition, many other employers are pursuing strategies to lower their liabilities for retiree health costs. Some employers are moving toward a defined dollar contribution model for retiree health benefits; this means that the employer offers coverage up to a specified dollar amount, rather than offering coverage for a specific package of benefits. Others are using Medicare+Choice plans and other managed care organizations to deliver services to their retirees. These employer choices have a significant impact on the supplemental health insurance available to program beneficiaries.

It is not entirely clear how the implementation of Medicare reform would affect the provision of employer-based retiree coverage. Obviously, this would in part depend on how the reform is structured. Some observers cite the decline in the percentage of employers offering such coverage; they suggest that this trend is likely to continue and might perhaps accelerate if employers saw reform as an opportunity to further reduce their involvement (though this trend might be countered somewhat by union contracts with large employers). Others suggest that certain reforms (for example, the addition of some prescription drug coverage) might slow the trend.

Many are concerned that any expansion in federal coverage might merely result in a dollar-for-dollar offset in coverage provided by employers. Under this scenario, federal dollars might increase but overall benefits for beneficiaries would remain relatively unchanged. Several prescription drug proposals attempt to address this concern by providing employers with financial incentives to maintain their drug programs and have their retirees continue to receive services through these plans rather than a new federal program.

Medigap. Beneficiaries with Medigap insurance have coverage for Medicare's deductibles and coinsurance and for some services not covered by Medicare. Beneficiaries generally select a Medigap policy from one of 10 standardized plans.²⁰ These are known as Plan A through Plan J. The Plan A package covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive.²¹

The intention of standardized policies is to enable consumers to better understand policy choices and to prevent marketing abuses. However, some observers suggest that the current policy options overemphasize first dollar coverage

²⁰ Beneficiaries who originally purchased supplemental policies before July 1992, can continue to renew these policies indefinitely. Approximately one-third of beneficiaries still have these policies. (Chollet, Deborah J., Senior Fellow, Mathematica Policy Research Inc., Testimony before Senate Finance Committee, April 24, 2001.)

²¹ For a discussion of Medigap see: CRS Report RL31223, *Medicare: Supplementary "Medigap" Coverage*, by Jennifer O'Sullivan

(namely coverage of Medicare's cost-sharing charges) which many beneficiaries could potentially budget for. At the same time, the plans provide less generous coverage for other services not covered by the program. (For example, only three standardized plans – Plans H, I and J – cover some drug costs and even the most generous requires significant out-of-pocket payments by beneficiaries.)

Many observers contend that Medigap premiums are difficult for many elderly individuals to afford.²² Some observers have suggested that policy options should be redesigned to place greater emphasis on catastrophic coverage. A change authorized by BBA added two high deductible plans to the list of 10 standard plans. With the exception of the high deductible feature, the benefit package under the high deductible plans is the same as under Plan F or Plan J. The removal of first dollar coverage was expected to result in lower premiums. However, these plans are not widely available.

Many beneficiaries tend to be risk adverse. They, therefore, purchase Medigap policies which protect them from most Medicare cost-sharing charges. While they face substantial premium costs for coverage, they may face little or no out-of-pocket costs at the time they actually use services. They thus perceive the service to be free and therefore use more services. Spending for beneficiaries with private supplemental coverage is estimated to be significantly higher than expenditures for those without such coverage. A review of 1995 data by the Physician Payment Review Commission (PPRC) showed that Medicare expenditures for beneficiaries having Medicare coverage *only* were less than 75% of those for beneficiaries with Medigap. (Medicare spending for beneficiaries with employer-provided benefits averaged 10% less than spending for persons with Medigap.) Higher Medicare spending reflects higher overall use of services. High service use among beneficiaries with secondary insurance appears to be a direct consequence of having such insurance. Comparison of service use between those with and without private coverage suggests that there may be some overutilization of services by those with supplementary coverage. However, some of the increased use of services likely represents the provision of appropriate care. Therefore, persons without supplementary coverage may not be getting some needed services.

Some observers suggest that as part of restructuring, the standardized Medigap policies should be redesigned to prevent first dollar coverage, for example, Medigap plans would be prohibited from paying the first \$250 in Medicare cost-sharing

²² There is wide variation in Medigap premiums for both drug and non-drug policies nationwide. This reflects a number of factors including differences in the benefits of Plan A through Plan J, differences in medical underwriting practices, and differences in pricing structures. For example, Weiss Ratings reports that in 2002, the premium for Plan A in Florida ranged from \$766 to \$2,028; the premiums in Texas for Plan F ranged from \$887 to \$2,487; and the premium in Arkansas for Plan J ranged from \$2,878 to \$9,376. Weiss further reported that the national average premium in 2002 for Plan F (the most commonly sold) was \$1,432. The national average premium for Plan J (the plan with the most drug coverage) was \$3,344. (Weiss Ratings, Inc., August 7, 2002 press release and information provided by Weiss official). These are premiums for a 65-year old male. A March 2000 GAO survey of 1999 Medigap premiums showed that average premiums for 75-year olds were higher than those for 65-year olds.

charges. The intent of this approach would be to make beneficiaries more cost conscious at the time they used covered services, thereby lowering Medicare spending. It should also result in a reduction in Medigap premium costs.

Many persons have suggested that if certain reforms were made to Medicare (for example, if there were an upper limit on out-of-pocket costs) beneficiaries would have less need to purchase Medigap policies. However, given the risk adverse nature of this population, it might be difficult to convince them that it was no longer necessary to purchase supplementary coverage. Further, the insurance industry would likely oppose an approach which could potentially result in a considerable loss in revenues.

Medicaid. Some low-income aged and disabled persons receive full or partial supplementary health coverage under Medicaid. Persons entitled to full Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these “dual eligibles” Medicare pays first. Medicaid picks up Medicare cost-sharing charges and provides protection against the cost of services generally not covered by Medicare, such as outpatient prescription drugs and long-term care.

Several population groups are entitled to more limited Medicaid protection. These are qualified Medicare beneficiaries (QMBs), specified low-income beneficiaries (SLIMBs), and certain qualified individuals added by BBA. QMBs are individuals with incomes below 100% of the poverty line and resources below 200% of the resource limit established for the Supplemental Security Income (SSI) program.²³ SLIMBs are persons meeting the QMB criteria except that their income limit is 120% of poverty. Medicaid pays Medicare’s cost-sharing and premium charges for the QMB population; it pays only the Part B premium for the SLIMB population. Medicaid coverage is limited to payment of these charges unless the individual is otherwise eligible for full Medicaid benefits.²⁴

Many persons eligible for QMB, or SLIMB coverage do not actually enroll in these programs. Many observers attribute the low enrollment rates to the fact that the programs are linked to Medicaid and therefore have a welfare stigma. However, the enrollment levels would likely increase if the benefits available to this population

²³ The 2002 monthly income limits for QMBs are \$759 for an individual and \$1,015 for a couple (these numbers reflect a disregard of the first \$20 of income). The resource limits are \$4,000 for a single and \$6,000 for a couple; certain items such as an individual’s home are excluded from the calculation.

²⁴ BBA added temporary coverage for two groups of “qualified individuals (QIs).” The first group (QI-1) was composed of persons, not eligible for Medicaid, whose income is between 120% and 135% of poverty. These persons were eligible to have their Part B premiums paid through a block grant program. Potentially eligible persons are served on a first-come, first served basis up to the state’s allocation limit under the block grant. The second group (QI-2) was composed of persons whose income is between 135% and 175% of poverty; these persons were only entitled to have a small portion of their Part B premium paid for (\$3.91 in 2002). QI-1s and QI-2s were never entitled to full Medicaid coverage. The programs ended December 2002; as of this writing they have not been extended.

group were expanded. For example, many prescription drug proposals would provide full or virtually full drug coverage to persons below 135% of poverty.

Medicare reforms that modify its benefit package could have specific budgetary implications for the Medicaid program. If Medicare's benefit package were expanded, Medicaid's obligations could potentially be reduced. Conversely, if Medicare's coverage were reduced (either through a reduction in services or the introduction of significant up-front cost-sharing), Medicaid costs could go up accordingly. States could choose to limit their cost increases by reducing the scope of Medicaid benefits. In this instance, beneficiaries would be entitled to fewer benefits.

The implications of any Medicare changes would depend, in part, on what portion of any new costs would be assumed by the federal government versus the state governments. Medicaid costs (including those for the QMB and SLIMB programs) are shared by the federal government and the states. Many states have specifically objected to "unfunded federal mandates;" in the case of Medicaid this occurs when the federal government mandates coverage of specific population groups and states are required to pay some of the costs. As a result of this concern, expanded coverage in BBA was primarily paid for by the federal government.

Protections for Low-Income

Policymakers are concerned about the health care coverage available to low-income populations. Persons with full Medicaid coverage have perhaps the most comprehensive supplemental protection. Those persons with partial Medicaid coverage have less generous protection. Low-income persons without any Medicaid coverage are also the least likely to have private supplementary coverage. This population group is viewed by many persons as being the most at risk for health care costs not covered by Medicare. Many reform proposals would target the low-income population (typically defined as below 135% or 150% of poverty) for special assistance.

Impact of Demographic and Other Changes

Medicare will begin to face the impact of the baby boom population in 2011. This will result in a rapid increase in the sheer number of aged Medicare beneficiaries over the ensuing 20 years. The baby boom population is likely to live longer than previous generations. This will mean an increase in the number of "old old" beneficiaries (i.e., those 85 and over).

The combination of these factors is estimated to increase the size of the Medicare population from 40.1 million in 2001 to 45.9 million in 2010 to 70.4 million in 2025.²⁵

²⁵ The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds. *2002 Annual Report of The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds*, March 26, 2002.

The number and health status of the aged population will also be affected by future advances in medical technology. Some changes will not only improve the health status of the aged but also prolong lives. The net impact on per capita health spending, and by extension on Medicare health spending, is difficult to predict.

Reform Options

As noted, the problems facing Medicare are not new. Until recently, the primary focus has been on enacting short-term measures designed to achieve budget savings and to postpone the Part A insolvency date. Generally this involved enacting legislation limiting increases in payments to providers, primarily hospitals and physicians. This approach culminated in the passage of the BBA. Limiting year-to-year increases in provider payments helped to lower the overall program growth rate and lengthen the solvency period for the Part A trust fund. However, most observers agree that broader reforms are needed to address both the long-term financing issues as well as to make needed program improvements.

The 108th Congress is expected to consider a variety of Medicare reform proposals. Some changes could be made while still retaining Medicare's current structure. Examples include increasing the program's eligibility age, introducing means testing, increasing beneficiary cost-sharing, and introducing innovations into the current fee-for-service program. Other changes could only be made in the context of major program restructuring. Proposals which have been suggested include modernizing the benefit structure, combining the Part A and Part B programs, or replacing the program's current guarantee of a defined benefit package with a premium support system. Many of the proposals could be combined as part of an overall reform package. The following is a discussion of some of the major proposals offered to date.

Increasing the Program's Eligibility Age From 65 to 67

The Social Security Act Amendments of 1983 (P.L. 98-21) was designed to address long-range financing problems in the Social Security *cash* benefits program. One provision in that law raised the full retirement age (the age at which one receives unreduced cash benefits) from age 65 to 67 over the 2003-2027 period. The Medicare eligibility age remained at 65.

Some persons have suggested that the Medicare eligibility age should be increased according to the same phase-in schedule established for Social Security benefits. (**Table 1** shows what the phase-in schedule would be under this approach.) The Senate-passed version of BBA included this provision; it proved very controversial and was dropped in conference. The Breaux-Thomas proposal considered by the Medicare Commission also recommended the same phased-in increase in the eligibility age; however, under that proposal an exemption process would be developed for affected beneficiaries with special needs, such as those unable to work and otherwise get health coverage.

Table 1. Proposed Eligibility Age by Year of Birth

Year of birth	Eligibility age	Year of birth	Eligibility age
Before 1938	65 years, 0 months	1955	66 years, 2 months
1938	65 years, 2 months	1956	66 years, 4 months
1939	65 years, 4 months	1957	66 years, 6 months
1940	65 years, 6 months	1958	66 years, 8 months
1941	65 years, 8 months	1959	66 years, 10 months
1942	65 years, 10 months	1960 and after	67 years, 0 months
1943-1954	66 years, 0 months		

Source: Table prepared by CRS.

Proponents of raising Medicare's eligibility age argue that it is reasonable given the increases in life expectancy and general improvements in health status that have occurred since the program was enacted in 1965. Average life expectancy for a 65-year old increased from 14.3 years in 1960 to 17.7 years in 1999.²⁶ Additionally, people in their 60s are in generally better health and perhaps could work a few more years.

Raising the age would result in program savings. The Senate-passed provision would have phased-in beginning in CY2003. CBO estimated that the provision would save \$10.2 billion over the FY2003–FY2007 period.²⁷ (Estimates were not made for savings over the full phase-in period.)

Opponents of increasing the eligibility age argue that it would place a number of seniors at risk. They cite the circumstances of the uninsured population aged 62-64 and suggest that the problems could be magnified for the population aged 65-66. Among the younger group, 15% were uninsured in 1998. Of these, 26% were poor and 52% were neither employed nor the dependent spouse of an employed person²⁸ — characteristics that would make it unlikely for these persons to be able to afford insurance. Employment-based group coverage generally spreads costs across *all* workers in the same health insurance plan. However, private non-group insurance premiums for persons 62-64 generally reflect the higher risk attributable to the *individual* policyholder's age and health status.

²⁶ DHHS, Centers for Disease Control and Prevention, National Center for Health Statistics. *Health, United States, 2002*. DHHS pub. no. 2002-1232. August 2002.

²⁷ Congressional Budget Office Cost Estimate. *S. 947/H.R. 2015, Balanced Budget Act of 1997, as passed by the Senate on June 25, 1997*. July 2, 1997.

²⁸ Shea, Dennis G., Pamela Farley Short, and M. Paige Powell. *Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare*. Health Affairs, January/February 2001.

Raising the eligibility age could have the effect of lengthening the period when some persons were uninsured or faced very high premiums for coverage. It is likely that those most affected would be lower-paid workers. This suggests that higher paid workers could keep their employment-based coverage for the additional 2 years. However, recent trends in retiree health coverage suggest that this might not be the case. A number of studies have shown that a declining share of large employers are offering health benefits to their retirees (though most grandfather in benefits for current retirees and those close to retirement). Further, the number of such employers charging premiums, tightening eligibility requirements, encouraging the use of managed care, and placing caps on coverage has increased.

The tendency of employers to restrict or drop coverage might be exacerbated if the proposal to increase the eligibility age were enacted. Many employers might decide that the provision of health insurance coverage for retirees was just too expensive. A report by Hewitt Associates²⁹ estimated that gradually raising the eligibility age to 67 (using the same schedule applicable for social security) would increase the actuarial costs for lifetime retiree benefits by 12% for large employers with a younger workforce and 8% for employers with an older workforce. Once the phase-in to age 67 were complete (or if there were no phase-in) the increase would be 16% for employers with a younger workforce and 18% for those with an older workforce. These figures reflect the fact that the employer's average per capita cost for a retiree before Medicare eligibility is about three times that of a retiree with Medicare coverage (\$4,000 vs. \$1,350 in 1997).

Raising the eligibility age would also have implications for Medicaid. Under current law, some low-income Medicare beneficiaries are also entitled to Medicaid on the basis of age (currently 65 or over) or disability. Medicaid supplements Medicare coverage for this group. If the Medicare eligibility age were raised, Medicaid would (under current law) assume some expenses previously assumed by Medicare. As a result, a portion of the anticipated Medicare savings would translate into increased federal and state Medicaid costs. Alternatively, the eligibility age for Medicaid could also be increased; however, this would leave some low-income individuals without any insurance coverage.

Means Testing

Medicare is not a means tested program. There are *no income or assets tests* for coverage. Further, the benefits and cost-sharing requirements are the same for all persons, regardless of income. Many observers have questioned whether this approach can be extended to any new prescription drug benefit. Some observers have suggested that any new drug benefit should be targeted primarily toward the low-income. Others have stated that the scope of coverage should be the same for all beneficiaries; however, low-income beneficiaries should receive additional assistance for premiums and cost-sharing charges.

²⁹ Hewitt Associates LLC. *Retiree Health Trends and Implications of Possible Medicare Reforms*. Report prepared for Kaiser Medicare Policy Project (Henry J. Kaiser Foundation Grant Number 96-1710B), Washington, September 1997.

Some observers have suggested that means testing should be incorporated into the current program. In this case, the focus would be on requiring higher income persons to assume a greater proportion of program costs. The most common proposal is that of means testing the Part B premium. Under current law, all persons enrolled in Part B pay a monthly premium equal to 25% of program costs. Federal general revenues account for the remaining 75%; (sometimes referred to as the federal subsidy). Many persons argue that it is inappropriate for taxpayers to pay three-quarters of Part B costs for high income Medicare beneficiaries. They point out that low and middle income working persons may be subsidizing higher income elderly persons. In response to these concerns, proposals to income-relate the Part B premium have been offered on a number of occasions.

The Senate-passed version of BBA would have provided for an income-related Part B premium for individuals with incomes over \$50,000 and couples with incomes over \$75,000. The federal subsidy would have been phased-out for individuals with incomes between \$50,000 and \$100,000 and for couples with incomes between \$75,000 to \$125,000. Individuals with incomes at or above \$100,000 and couples with incomes at or above \$125,000 would have paid 100% of program costs.³⁰ At the time BBA was considered, it was estimated that approximately 5% of the noninstitutionalized aged population would have experienced higher Part B premiums.

The Senate-passed BBA provision was controversial and was dropped in conference. Many observers are reluctant to introduce means testing into the current program. They note that once means testing is approved, it would be easier to lower the income threshold at some future date as part of a budget savings measure. Means testing could thus affect persons with more modest incomes. Another concern is that if some beneficiaries are required to pay 100% of Part B costs, they might drop Medicare Part B and seek alternative coverage. At this point, insurers do not market Part B coverage (except for supplementary coverage) to the over-65 population. However, this might change if insurers felt there was a market for this type of product. If too many healthier people dropped Part B, this could potentially result in adverse selection, with sicker people staying in Part B and driving up the per capita costs.

The major issue during the 1997 debate was how means testing would be administered. Many claim that income-relating the Part B premium would be costly to administer because of the need to obtain and verify income information. While available through Internal Revenue Service (IRS) records, there is no other currently operational system of identifying income. The Senate-passed version of BBA had proposed that a parallel system to the IRS be created through CMS to identify income level. Some argued that this proposal would have required a large resource

³⁰ For example, the 2003 Part B premium is \$58.70 per month (\$704.40 per year) which represents 25% of costs; the federal subsidy is \$ 176.10 per month (which represents 75% of costs). Over the year, the federal subsidy is \$2,113.20. If the Senate provision were in effect, individuals with incomes over \$100,000, would be subject to a Part B premium of \$234.80 a month (\$2,817.60 a year, 100% of costs). Individuals with incomes between \$50,000 and \$100,000 would have monthly premium amounts between \$58.70 (the current amount) and \$234.80.

commitment. Many argue that given that the IRS already accesses income data, it should be the entity to administer an income-related premium. However, others are concerned that if the IRS administers the income-related premium it will be viewed as a tax.

It should be noted that income verification for the low-income population (for example for a new drug benefit) poses different issues. State Medicaid programs already have an eligibility determination system in place, though they may not have sufficient resources to assume the increased administrative burdens. Most prescription drug proposals which rely on states to perform the eligibility function would provide some additional federal assistance. In addition, states would realize savings for those drug costs, previously paid by Medicaid, but now paid under the federal program.

Modifications in Beneficiary Cost-Sharing

Some observers have suggested that beneficiary cost-sharing should be modified. Some proposals would be limited to changing existing cost-sharing levels. Other proposals, such as adding a catastrophic out-of-pocket limit, would likely be linked to broader benefit design changes.

Proposed changes in current cost-sharing requirements include increasing the Part B coinsurance from 20% to 25%, increasing the Part B deductible from the current \$100 to a level more comparable to that in private insurance plans (such as \$200-\$250), and imposing coinsurance on services not currently subject to such charges (such as home health care and lab services).

Increased cost-sharing would presumably make beneficiaries more cost conscious in their use of services. However, some persons are concerned that increasing cost-sharing charges could impede access for some beneficiaries. Data show that 64% of Medicare beneficiaries had incomes below \$25,000 in 2000.

Most beneficiaries have supplementary coverage and therefore would not directly feel the impact at the time they obtained services. Persons likely to be most immediately affected by changes in cost-sharing requirements are persons in fee-for-service Medicare without any supplementary health insurance coverage. Many of these individuals have incomes above the levels necessary to qualify for full Medicaid or QMB coverage but not high enough for them to obtain other supplementary protection.

Beneficiaries with employer-based coverage might or might not see increased out-of-pocket expenses if cost-sharing charges were raised. This would depend on their employer's response. As noted previously, a number of employers are rethinking the amount of supplementary coverage they are offering their retirees. Beneficiaries with Medigap insurance (which covers cost-sharing charges) would likely see increased premium charges unless Medigap modifications were made at the same time. However, as noted earlier, other factors could offset these increases. These include the addition of an out-of-pocket limit on Medicare cost-sharing charges (catastrophic cap) and/or the prohibition on coverage of first dollar costs under standardized Medigap packages.

Redesign the Medicare Benefit Package

Many observers state that Medicare's benefit structure does not reflect the current health care delivery system. As noted earlier, Medicare's benefit package is somewhat less generous than typical employment-based coverage. Some persons have suggested that a redesign is appropriate. They recommend inclusion of such additional items as prescription drugs or a limit on out-of-pocket expenses (sometimes referred to as a catastrophic cap). However, such expansions have the potential for significantly increasing Medicare's costs. (The possible coverage of prescription drugs raises a series of program design issues. These are addressed in a separate CRS report.³¹)

Other program reforms would, by definition, affect benefit design. For example, under a premium support system (discussed later) beneficiaries might be given more freedom in selecting a benefit package tailored to their individual needs. Any benefit redesign would need to be considered in the context of the entire package of benefits available to the Medicare population, including their supplementary coverage. For instance, a program change which increased beneficiary cost-sharing charges might at the same time include a broader benefit package and thus lessen the need to purchase Medigap policies.

Medigap Modifications

Some have suggested that incentives in current Medigap policies should be revised. As noted earlier, beneficiaries with Medigap coverage tend to perceive services as "free" at the point when they are actually using them; thus they use more services and cost Medicare more dollars than those without supplementary coverage. Another concern is that while current Medigap policies offer good protection against some Medicare-related costs, they offer less adequate protection against other potential expenses of the elderly. For example, even the most generous Medigap policy (Plan J) limits coverage for prescription drugs to 50% of the cost of prescriptions after the policyholder meets a \$250 per year drug deductible; the maximum annual drug benefit is \$3,000.

The BBA permitted beneficiaries to purchase policies which have high deductibles in exchange for lower premium charges. The intent was to enable beneficiaries to obtain *catastrophic* Medigap protection at a lower premium charge. However, these plans are not widely available.

As noted earlier, some analysts have suggested taking this approach a step further by *prohibiting* some or all of the 10 standard Medigap packages from offering first dollar coverage. This presumably would make beneficiaries more cost conscious in their use of services and by extension lower Medicare costs. It should also have the advantage of lowering Medigap premiums. However, the elderly are generally risk adverse and tend to want full coverage. Some of this concern might be allayed

³¹ CRS Report RL30819, *Medicare Prescription Drug Coverage for Beneficiaries: Background and Issues*, by Jennifer O'Sullivan.

if provision were made for full coverage after an individual had incurred a certain level of catastrophic expenses.

Combine Part A and Part B

Frequently, proposals to redefine Medicare's benefit structure include a recommendation to combine the current Part A and B programs. Many persons suggest that Medicare's current two part structure is no longer appropriate. They note that the vast majority of beneficiaries are enrolled in both programs. They also cite the program's increasing emphasis on managed care approaches and the fact that the Medicare+Choice program requires enrollment in both Parts A and B. The Breaux-Thomas proposal considered by the Medicare Commission would have combined Part A and Part B. It would have replaced the separate Part A and Part B deductibles with a single \$400 combined deductible (in 2003), indexed in future years to the growth in Medicare costs.

A variation of this approach was the "21st Century Medicare Act" (S.2729, the "tripartisan bill") offered by Senators Grassley, Snowe, Jeffords, Breaux and others in the 107th Congress. Under this bill, beneficiaries could elect to receive benefits under a new Part E, instead of under the existing Parts A and B. The revised benefit package would have established a unified deductible, set a catastrophic cap on out-of-pocket costs for all covered services, eliminated cost sharing for preventive care, and modified cost sharing requirements for hospital services, home health care and skilled nursing facility services. The existing Part A and B programs would have been retained and payments would continue to be made from the appropriate fund. In addition, the current financing mechanisms would be retained.

While many observers agree that the current structure may not be the most appropriate in the face of today's realities, they question how the two vastly different systems can be combined. Of particular concern are the two different financing structures. Part A is funded by current workers through a payroll tax, while Part B is funded by current beneficiaries and federal general revenues. Under the current design, Part A becomes insolvent when assets in the trust fund are not sufficient to meet current obligations. Under current law, no general revenue financing is available for Part A. A combination of the two programs could potentially alter this situation, since all revenue sources would potentially be combined into a single fund. Many are concerned that if the two programs were combined, there would be less incentive to control costs since "general revenues would be available." Alternatively, combining the two programs could also result in a new test for the availability of general revenue financing.

The Breaux-Thomas proposal presented to the Medicare Commission included a new measure of Medicare solvency. Under the proposal, Part A and B trust funds would be combined into a single fund with current revenue sources from both funds maintained. Congress would be required to authorize any additional contributions to the new trust fund in any year in which general revenue contributions were expected to exceed 40% of annual outlays. At the time the proposal was considered (early 1999), this trigger was not expected to be reached until after 2005. "Breaux-Frist 1" (S. 357 in the 107th Congress) contained similar provisions.

Fee-for-Service (FFS) Modernizations

Some have suggested that Medicare's FFS program should incorporate certain managed care techniques which are currently used by private insurers in their indemnity insurance products to control spending and improve patient outcomes. Specifically, Medicare could establish disease and case management programs that identify and enroll individuals with certain health conditions in order to provide higher quality of care at lower costs.³² Under these programs, Medicare beneficiaries with health conditions such as congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension, arthritis, or chronic pain could elect to participate in case management programs which would provide patient education (for self-management of chronic conditions), prevention and management of services, or other flexible benefits. The programs would employ tools such as data analysis to help identify and target beneficiaries, bundled payments to physicians and other providers (for all items and services used during an episode of care) and prior authorization or review of services that could also be incorporated more generally into FFS Medicare. Congress took steps in this direction in BBA by authorizing payment for diabetes self-management training services and in BIPA which required a 3-year disease management demonstration project that included coverage for prescription drugs.

Others recommend that Medicare be permitted to use selective contracting or to provide beneficiaries incentives to use selected providers. Some private plans restrict enrollees to providers who meet certain cost or quality standards; others preserve enrollees' freedom of choice but give them financial incentives to choose preferred providers. Presently CMS does not have the statutory authority to establish or contract with networks of preferred provider organizations in Medicare FFS, though Medicare+Choice does include this option. CMS recently launched a preferred provider organization (PPO) payment demonstration in an effort to increase PPO participation in the M+C program.

Finally, some believe that CMS should use competitive pricing or improved procurement practices when paying for both health care and administrative services. Private health plans use their buying power in the marketplace to realize savings in the cost of goods and services through negotiated pricing. Aside from limited demonstration projects,³³ CMS sets payment rates through different rate-setting methods (sometimes referred to as *administered pricing*) not competition between

³² Generally, case management programs target "high-risk" patients who are likely to suffer costly hospitalizations and adverse health outcomes because of complex social and medical vulnerabilities; disease management programs target patients with a relatively standard set of needs related to a specific disease, although certain comorbid conditions may be addressed as well.

³³ For example, BBA authorized five competitive bidding demonstration projects for nonphysician Part B services such as laboratory and durable medical equipment supplies in competitive acquisition areas where private payers paid less than Medicare. Under the demonstration, CMS is required to protect beneficiaries' access to a broad range of providers and suppliers as well as to maintain a viable number of providers and suppliers in the marketplace to assure an effective procurement process in future years.

or negotiation with health care providers. Even when purchasing claims processing services, CMS is required to contract exclusively with certain private health insurers for functions related to paying FFS bills and reimburses the insurers their costs for these services.³⁴ At a minimum, analysts propose that CMS be able to solicit competitive bids and contract with entities other than insurance companies to provide claims processing services.

These changes, in one form or another, have been recommended for consideration by the National Academy of Social Insurance,³⁵ were discussed by the Medicare Commission, and were part of the Clinton Administration's proposal to modernize Medicare. However, there are no systematic data establishing the prevalence of these managed care tools in the private sector. Still, evidence indicates private insurers use many of the managed care tools primarily to control costs and, to some lesser extent, enhance quality. At best, however, the literature on the effectiveness of these programs with respect to cost savings or quality improvement is mixed and there is little hard evidence that these programs save money or enhance the coordination of care.

It should be noted that CMS has established various demonstration projects to test the applicability and effectiveness of many of these managed care tools, including case management, disease management, selective contracting, bundled payments, competitive pricing and competitive procurement. Some of the projects are ongoing; some have not yet been started; others are long completed. Depending upon the project, the results have been mixed in terms of cost savings, implementation costs, impact on utilization, beneficiary interest, and provider resistance. Although small scale experiments are necessary in order to learn (and are viewed as more prudent than wholesale changes to the program), the projects take a long time to set up and are temporary by design.

However, at this point, most Medicare beneficiaries continue to receive care in Medicare FFS where overuse, underuse and misuse of services are thought to be common. Historically, a small proportion of Medicare beneficiaries has accounted for a major proportion of Medicare expenditures. In 1996, 12.1% of Medicare beneficiaries accounted for 75.5% of Medicare FFS payments. Many of the high-cost beneficiaries are chronically ill with certain common diagnoses with much of the Medicare expenditures attributed to repeated hospitalizations. As the population ages, and life expectancy extends, the number of these beneficiaries is expected to grow. According to some, Medicare FFS often fails to meet the needs of chronically ill people, because: (1) treatment regimens for chronic illness often do not conform to practice guidelines; (2) care is frequently rushed and overly dependent on patient initiated followup; (3) providers typically devote little time to assessing function,

³⁴ The Health Insurance Portability and Accountability Act (HIPAA) established the Medicare Integrity Program (MIP) and gave CMS the flexibility to contract with other entities to perform certain program safeguard functions that had been part of the claims processing contracts.

³⁵ *From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare*, Final Report of the Study Panel on Fee-for-Service Medicare, National Academy of Social Insurance. January 1998.

providing instruction in behavior change or self-care, or addressing emotional or social distress; and, (4) finally, care is fragmented, with little communication across settings and providers.³⁶ In essence, Medicare spends a large amount of money on a small proportion of chronically ill beneficiaries; many unplanned hospitalizations of these beneficiaries appear to be preventable; and care might be better managed if FFS Medicare were changed so providers had stronger incentives to do so.

Some of the FFS modernizations discussed here face major hurdles in implementation. Medicare FFS accounts for a significant portion of revenue for physicians, hospitals, other providers and suppliers. Innovations that steer FFS Medicare business away from some providers or are perceived as inequitably benefitting some providers at the expense of others can cause economic disruptions in the marketplace, will be controversial, and may elicit a call for congressional intervention. Similarly, a program targeting certain beneficiaries that is perceived as advantageous by other excluded beneficiaries may be controversial as well. Some believe that managed care techniques that are available to private insurers may be significantly more difficult for Medicare to adopt.

Premium Support

One technique for restructuring the Medicare program is a premium support system, an approach for providing financial assistance (a premium subsidy) to individuals for the purchase of their health care insurance. Individuals would be able to choose from a set of competing plans and use their subsidy to pay all of or part of the plan premium, depending on the level of the subsidy and the actual premium charged by the plan. The level of premium support could be set at a fixed dollar amount, or at a fixed percentage of the total plan premium. While the premium subsidy would be set at basically the same amount for all participating individuals (with adjustments in payments for geographic variations, demographic and other risk factors), the decision as to what constitutes the benefit package and payments to providers could be left completely or partially to the discretion of the entities offering the health insurance. Options for approved benefit packages could range from allowing a limited choice among only one or two benefit packages with a core set of benefits to allowing maximum choice by placing no restrictions on the design of the benefit package, or anywhere in between.

The goal of a premium support approach is to give individuals some amount of flexibility to choose the health insurance coverage that meets their needs, along with incentives to choose plans that are the best value for them within financial constraints they may have for supplementing the premium subsidy. The premium support model differs from the current Medicare program model which operates as a defined benefit model with administered pricing. The current Medicare program guarantees beneficiaries a defined set of benefits under an open-ended entitlement program and determines the prices that will be paid to providers. Under premium support, beneficiaries would instead be entitled to a *level of support* for their Medicare covered services.

³⁶ For further information see, Chen, Arnold, et al. *Best Practices in Coordinated Care*. Washington, Mathematica Policy Research, March 22, 2000.

Variations of the premium support concept have emerged as one of the leading proposals for re-inventing or restructuring Medicare. Proponents say it would both reduce Medicare spending growth and provide a more efficient health care insurance model for Medicare beneficiaries. Just as Medicare was originally designed to reflect the structure of private health insurance in 1965, many argue that the program has not kept pace with market innovations and with health insurance plan coverage typically provided today. As a result, they contend, the current Medicare program reflects an antiquated system that must be reformed. At the core of the debate on premium support is the tension between those who want to control spending growth and those beneficiaries who are concerned about reform and any increases in their out-of-pocket costs.

In essence, a shift from a defined benefit program to a premium support program would represent a major paradigm shift in health insurance coverage. For the Medicare program and population in particular, there are a number of special issues and problems related to a shift from a defined benefit program to premium support program.

Derivation of Premium Support. Many health economists have proposed that price competition among health plans would improve the efficiency of health care spending. In fact, premium support is a variant of “managed competition” purchasing reforms advocated by Alain Enthoven and other economists. In 1995, Aaron and Reischauer³⁷ introduced their concept of premium support for Medicare. They defined a Medicare premium support system as one in which Medicare would pay a defined sum toward the purchase of a health insurance policy that provided a defined set of services. In effect, Medicare beneficiaries would receive a predetermined amount of money (a premium subsidy) to use towards the purchase of a health plan, which would in turn provide a defined set of benefits. They proposed to vary federal support across health care markets, but not within an area.

Aaron and Reischauer’s premium support model would involve: 1) defining the health-care market area; 2) accepting bids from entities for the provision of the defined benefit package; 3) developing local marketing organizations to handle the sale of insurance that would assist Medicare beneficiaries; 4) providing “risk-adjusted payments,” that is payments which would vary based on an individual’s demographic and health factors; and 5) phasing-in the system using a blend of cost-based and per-capita (a fixed dollar amount per person) reimbursement. Each of these components raises a number of implementation issues. The first question is how to make this dramatic change more acceptable to beneficiaries. Their solution involved redesigning the benefits package to include some form of prescription drug benefits as well as catastrophic coverage. They envisioned a standard benefit package, along with standardized cost-sharing requirements, so that participants could more easily compare costs and quality.

However, others argue that there is a trade-off between standardizing plans to make it easier to compare benefits and allowing maximum choice and flexibility by

³⁷ Aaron, Henry J., and Robert D. Reischauer. *The Medicare Reform Debate: What is the Next Step*. Health Affairs, winter 1995.

permitting insurers to design different plans for the varying needs of the population. More flexibility would give individuals more choice to purchase the health insurance that fits their needs and budget. The current Medicare+Choice program requires that all private plans offer the standard Medicare benefit package and then provides strict guidelines for adding services, with specific cost-sharing requirements. This differs from the federal employees health benefits plans (FEHBP), which has established few minimum benefits requirements and, therefore, provides both plans and purchasers maximum flexibility. Opponents of offering an FEHBP type plan to Medicare beneficiaries claim that seniors need the standardized plans to eliminate confusion and guarantee adequate and appropriate coverage.

Determining a suitable federal contribution, or premium subsidy, raises other issues. Aaron and Reischauer suggested setting the federal payment at 95% of the cost of the current Medicare package in each market area, with some adjustments. Over the phase-in period, the federal contribution would be set to grow more slowly than projected current-law baseline costs, so that in the long run, the federal Medicare contribution would reflect the per capita spending growth of the non-elderly. Aaron and Reischauer recognized this model had the potential to lead to risk segmentation caused by income differences. Risk segmentation occurs when individuals with a larger risk of consuming medical services are in one set of plans, while those individuals with a smaller risk of using services are in another set of plans. Because higher income individuals tend to be healthier than lower income individuals, plans with high deductibles and high cost-sharing would attract relatively wealthier and therefore healthier beneficiaries. To counter this and to provide more equity, their model would require both supplements for low-income participants to allow this population to have some choice among plans and risk-adjusting the government contribution to ensure that plans that enrolled higher-cost individuals would be reasonably compensated.

The infrastructure necessary to sustain a Medicare premium support system would take time to build. It would be necessary to create an environment of competition among plans, develop the apparatus to regulate the marketing of insurance, implement risk adjustment procedures³⁸ and overcome difficulties of increasing Medicare costs for many current beneficiaries. They suggested dual Medicare systems – the “old” program for current enrollees, and the new structure for newly eligible beneficiaries, while acknowledging that new enrollees might not provide a sufficient population base for this phase in. They would leave in place the Medicare system of administered pricing, at least during the transition period, as well as significant federal regulation, to ensure that the new system could be shored-up in case of a failure.

Evolution of Premium Support. Since the original Aaron and Reischauer plan, a number of different proposals have been offered for establishing premium support. As one study pointed out, despite their differences, premium support

³⁸ Medicare+Choice payments are currently risk adjusted to account for variations in demographic characteristics and inpatient hospital stays. Beginning in 2004, a new risk adjustment methodology will be phased-in that will also include data from ambulatory settings.

models tend to share 6 core features:³⁹ 1) beneficiaries would be able to select a Medicare approved plan on an annual basis; 2) plans would calculate and then submit a “bid” for the total premium amount they would charge; 3) the “bids” would provide a basis for calculating the federal payment amount; 4) the federal government would provide a fixed premium subsidy; 5) beneficiaries would pay different premiums, depending on the plan they selected; and 6) the traditional Medicare program would compete on the same terms as private plans. Policymakers have yet to reach consensus on these six elements. For example, some premium support proposals require the Medicare FFS program to compete on the same playing field as private plans, while others do not include FFS in their premium support model.

As noted earlier, the “Breux-Thomas” proposal presented to the Medicare Commission would have provided premium support to pay part of the total premium for an approved health plan selected by a Medicare beneficiary. The FFS program would compete for enrollment on the same basis as other approved private plans, so that the government would pay a portion of the cost of providing traditional Medicare-covered benefits. Under the proposal, a new Medicare Board would be established to administer the program, and would be given broad powers to oversee and negotiate with plans.

Building on the Commission’s model, “Breux-Frist 1” introduced in the 106th Congress would have set the premium subsidy at 88% of the nationally weighted average of plan premiums. Beneficiary premiums would vary depending on the cost of the plan they selected, ranging from potentially no premium to premiums covering all of the excess costs that exceeded the subsidy level. Plans would be required to provide a benefit package equivalent to current Medicare coverage, called core benefits. All plans, including Medicare FFS, would be required to offer high-option plans that included some prescription drug coverage and coverage to limit yearly Medicare out-of-pocket expenditures for covered services other than drugs. Subsidies would be provided to low-income beneficiaries to purchase at least one of the high option plans covering prescription drugs. Plans would submit bids, providing information about benefits covered under the plan, the proposed premium to be charged for enrollment, and the service area. Plans would be allowed to have reasonable variation in cost-sharing. The proposal also included the establishment of an independent Medicare Board to oversee health plan competition and beneficiary choice.

President Clinton also outlined a proposal for Medicare restructuring during the 106th Congress. This was largely incorporated into legislation introduced by Senator Moynihan (S.2342, The Medicare Modernization Act of 2000). This legislation would have created a competitive defined benefit program, administered by CMS (then HCFA), that allowed for competitive bids for a standard Medicare benefit package. This legislation differed from previous premium support proposals, because it did not include the FFS program in the competitive bidding process. However, prescription drug coverage was included in this legislation.

³⁹ Oberlander, Jonathan. *Is Premium Support the Right Medicine for Medicare?* Health Affairs, September/October 2000.

Subsequently, Senators Breaux and Frist introduced S.2807, the Medicare Prescription Drug and Modernization Act of 2000 (Breaux-Frist 2), which was a scaled down version of Breaux-Frist 1. This bill would provide for optional Medicare prescription drug coverage, establish a Competitive Medicare Agency similar in concept to the Medicare Board, and allow for competitive bidding within the Medicare+Choice program. However, this bill did not include FFS in the competitive bidding process.

Legislative Activity in the 107th Congress. As noted earlier, slightly revised versions of “Breaux-Frist 1” and “Breaux-Frist 2” were introduced in the 107th Congress (S.357 and S.358). Additionally, on June 28, 2002 the House passed H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002, which included provisions similar to components of premium support. The Senate considered S. 2729 (introduced by Senator Grassley et al., - the Tripartisan option),⁴⁰ legislation that included an option for restructuring Medicare. Both H.R. 4954 and S. 2729 included options for prescription drug coverage. M+C beneficiaries could choose, but were not required to elect, plans with the new prescription drug benefit.

H.R. 4954 would have established a new Medicare+Choice competition program, as well as a new demonstration program in no more than 4 sites chosen from those areas with high concentrations of M+C enrollees. Under the competition program, M+C plans would submit a bid for the premium amount they planned to charge and once accepted, the premiums would be measured against a government set benchmark amount (similar to the concept of a premium subsidy). Medicare enrollees would choose an M+C plan and if the subsidy was less than the plan premium, enrollees would have to pay the additional amount for these more expensive plans. Conversely, Medicare beneficiaries would qualify for a rebate for enrolling in less expensive plans.

While the competition program under H.R. 4954 would only affect M+C enrollees, the demonstration program could affect all Medicare beneficiaries residing in the demonstration area. In the demonstration program, the government would set its benchmark (or premium subsidy) to incorporate both FFS and M+C components. In addition to potential premium “adjustments” for M+C enrollees, those FFS enrollees residing in the demonstration area would also be eligible for rebates or subject to increased Part B premiums depending on the FFS bid in the demonstration area. If FFS beneficiaries were required to pay higher premiums, then some healthier beneficiaries who did not want to pay an increased amount might switch from FFS to a lower cost M+C plan.

Under S. 2729 (the Tripartisan option), Medicare beneficiaries would be entitled to elect to receive enhanced Medicare benefits under a new Part E. There would be a unified deductible along with a serious illness threshold so that beneficiaries would not be responsible for any cost-sharing (deductible, coinsurance and copayments) once this threshold had been reached. For individuals choosing managed care, there would be a new M+C payment system. Each year the Secretary would calculate a

⁴⁰ S. 2729 was actually considered as S.Amdt. 4310 during the debate on S. 812, the Greater Access to Pharmaceuticals Act.

benchmark amount (or premium subsidy) for each M+C payment area, to cover Medicare benefits under Part E. The Medicare Commissioner for the Medicare Competitive Agency (a newly created agency in this legislation) would determine the difference between each adjusted plan bid and subsidy in order to determine the payment amount, the Part E premium, and the M+C monthly basic beneficiary premium reduction. Similar to the competition program in the House bill, Medicare M+C enrollees would pay additional premiums for more expensive plans or conversely, they would qualify for a rebate for enrolling in less expensive plans.

Current Issues. As the 108th Congress debates various options for modernizing the Medicare program, many issues will be considered. For example, changes to the program could be broad and encompass the entire program, including FFS and managed care, or could be more limited, changing just one segment, such as beneficiary cost-sharing or managed care. If changes to FFS are included, then perhaps the largest stumbling block is the potential for higher than expected premiums for beneficiaries who choose to remain in Medicare FFS. The CMS actuaries estimated that under the original Breaux-Frist 1 plan, enrollees remaining in FFS in 2003 could expect to pay premiums that were 47% higher than the Part B premium under current law.⁴¹ Although a larger premium subsidy could reduce this differential, any expected savings to the Medicare program would also be lowered. The domino effect of Medicare FFS plan price spiraling could further serve to increase FFS costs. As relatively healthy beneficiaries decided that the FFS premiums were no longer a good value, they could make the decision to move to lower cost plans, thus leaving a smaller pool of higher-cost beneficiaries in FFS. This smaller pool of sicker beneficiaries would further drive up the costs of FFS Medicare. For the majority of Medicare beneficiaries who are currently in FFS, these changes could prove to be very unsatisfactory.

Comprehensive Medicare reform would not only affect beneficiaries, it would also have a significant impact on health care providers and others who have an interest in the Medicare program, such as suppliers and persons investing in health plans. The success of a major innovation, such as premium support, would depend in a large part on the way these groups viewed and then responded to the changes.

Other components of a premium support model each present their own challenges, and the possibilities for combinations of different solutions are huge. For example, S.357 would offer a limited number of plans, so as to minimize beneficiary confusion and make comparing plans for quality and efficiency relatively easy. The age, disability, and health care needs of the Medicare population are significant hurdles faced by policymakers seeking major Medicare changes, and a standardized package could be designed to address common needs of this population, while minimizing confusion about plan comparability. This is similar to the current structure of the Medicare+Choice program. However, limiting the variety across

⁴¹ Memorandum written by Rick Foster, Office of the Actuary on February 23, 2000. The 47% increase could be even higher if more beneficiaries choose to enroll in plans that cost less than FFS. This estimate assumed no change in the distribution of enrollees in private plans versus FFS.

plans would make it more difficult for plans to offer maximum choice to beneficiaries and to tailor plans for different health care preferences and needs.

Developing a premium “bid” that would cover a core benefit package is viewed as one of the cornerstones of Medicare structural reform, because it would introduce competition into the Medicare system by allowing plans to independently determine the premium they would charge. Under the current Medicare+Choice program, plans are given a preset per capita amount for each enrollee, with explicit rules for determining cost-sharing and premiums. Under Medicare’s current rules, a plan may not earn a higher rate of return from its Medicare business than it does in the commercial market.⁴²

Another feature of a premium support model involves determining the federal government level of the premium subsidy and then providing that subsidy to beneficiaries. Subsidies could be set as a percentage of the average or the total of the plan “bids”, so that higher-cost plans would require larger beneficiary contributions. The opposing issues here are saving money versus providing incentives for beneficiaries to choose the plans that fit their needs. The higher the subsidy, the fewer incentives individuals would have to act as prudent purchasers. Once coverage is purchased, there is even less incentive to act as a prudent purchaser. However, the smaller the subsidy, the less “choice” or flexibility low-income individuals would have in choosing a plan. If FFS were to become a relatively expensive option, then low-income individuals and even individuals living in areas with no alternative to FFS would be placed in a particularly disadvantageous situation.

In a premium support model, premiums for the approved plans may vary depending on the plan selected. Thus individuals choosing more expensive plans would be required to pay a larger share of the premium. For individuals with limited resources, this could translate into limited choice. They might only be able to select plans with little or no additional premiums above the subsidy level. While a larger premium subsidy for low-income individuals would reduce or eliminate this problem, depending on the level of the subsidy, savings to the Medicare program could also be reduced. As previously discussed, this division between higher-income and therefore healthier beneficiaries could lead to risk segmentation as well as issues of inequality.

Other issues that must be considered for restructuring include how to best gain beneficiary support and acceptance; and how to implement, phase-in, and administer such a program. To the extent that beneficiaries envision this reform as part of a larger plan to modernize the Medicare benefit package, including the provision of prescription drug coverage and stop-loss coverage, they might be more willing to accept broad Medicare reform. This comprehensive change may best be diffused by phasing-in such a system, although again the various methodologies offer a trade-off between savings and efficiency. Opponents of such a system would be quick to point out that once a premium subsidy is set, it would be relatively easy to achieve

⁴² See CRS Report RL30702, *Medicare+Choice*, by Hinda Chaikind, Madeline Smith and Paulette Morgan, for a detailed discussion of payments and benefits in the Medicare+Choice program.

budgetary savings by either reducing the percentage or even holding it constant in the face of inflationary increases and changes in medical technology. Over time, the subsidy could erode to represent a smaller and smaller share of the actual cost of total premiums. Effectively only those with higher incomes would be able to afford the higher-cost plans, as they became even more expensive.

Another key consideration is the participation of plans. The current Medicare+Choice program is experiencing difficulties as plans withdraw from the program. Ensuring that the premium support model was more attractive to plans so that they would choose to participate and then remain in the program would be crucial. Today, few plans are available in rural areas, in part because of the difficulty of forming provider networks. Most individuals in these areas must rely on FFS, not because they necessarily prefer this option, but because there is no other choice for Medicare coverage. If FFS is included in a premium support model, and FFS becomes an higher-cost option, then financial protections for individuals with little or no choice may be necessary to guarantee equity. However, if FFS is not included in a premium support model, then it would be difficult to contain Medicare growth.

Medicare Administration Restructuring

CMS is responsible for the oversight and administration of the Medicare program as well as other duties. CMS is located within the Department of Health and Human Services. The Administrator of CMS is appointed by the President, confirmed by the Senate, and reports to the Secretary of Health and Human Services. In the summer of 2001, CMS was reorganized to concentrate the major policy and operations functions of fee-for-service Medicare into the Center for Medicare Management and to concentrate the policy and operations functions of Medicare+Choice and beneficiary enrollment and education functions into the Center for Beneficiary Choices.

Several of the reform bills proposed in both the 106th and 107th Congresses would have changed the administrative structure of Medicare. Other bills would have placed the administration of a new prescription drug benefit in the current CMS. Much of the impetus for restructuring stemmed from the belief of some observers that the Medicare agency was neither responsive nor capable of administering complex new benefits such as a prescription drug benefit. As a developer and administrator of administered pricing formulas, some believed that the Medicare agency did not have (and could not attract) staff capable of running a much more competitive and dynamic benefit. They also believed that there was an inherent conflict of interest in administering both the existing fee-for-service and a new managed care program. Critics of wholesale restructuring believed that the problems of the agency arose from chronic underfunding and a dramatically increasing workload, especially since passage of BBA.

Some of the proposals would have established a Medicare Board, either to administer the new agency or to act as an advisory committee to the entity responsible for program administration. To varying degrees, the new administrative entity would be given greater flexibility in managing the program than CMS now has.

An alternative plan replaced CMS with two separate agencies within HHS: one agency would administer Medicare, the other would administer Medicaid and other state-operated health programs.⁴³ Proponents of this change suggested that even with additional resources, the operational tasks currently assigned to CMS are unwieldy and would overwhelm any administrative entity charged with oversight of Medicare. Critics, however, cite the need for coordinated federal action in health care due to overlapping activities, such as survey and certification efforts, that affect the Medicare and Medicaid programs jointly as one reason to keep CMS's current functions together in one agency. In their view, the 2001 administrative reorganization of CMS that established separate administrative entities within the same agency may have been an adequate response, particularly if agency resources are increased.

It is unclear whether the 2001 reorganization satisfies critics of Medicare's management. Some may remain skeptical whether CMS could oversee an expanded, more complex Medicare program, in part, because they doubt that the agency's internal culture, geared toward regulation of the fee-for-service program, could ever be reoriented to administer competitively-based programs. They also question whether conflict exists in administering both the existing fee-for-service and a competing new managed care program. Moreover, some express concern over the willingness of CMS to adapt its regulatory approach if it manages a new prescription drug benefit. On the other hand, others see the possibility that the change in agency leadership may transform the agency's culture and regulatory orientation. Some point to greater efforts to communicate agency policy and hear from stakeholders as evidence of change. Further, some believe that the agency's efforts to implement a prescription drug card may give the agency the needed administrative expertise in the area of prescription drugs.

Still other analysts contend that problems with Medicare's administration stem from inadequate resources, not necessarily organizational shortcomings. In an open letter to Congress in January 1999, 14 experts representing a variety of perspectives, cited the unwillingness to provide CMS with the resources and administrative flexibility to accomplish its assigned tasks as the source of the agency's difficulties. In their view, these constraints had been imposed at a time when Congress had imposed additional responsibilities and some of the agency's most capable administrators had left. These concerns have not been allayed by the change in the agency's management, name, or structure.

Depending upon the administrative structure selected, two separate agencies responsible for administering different elements of a Medicare program could face programmatic and managerial problems, such as inconsistent treatment of Medicare beneficiaries, confusion among beneficiaries and providers, conflicting regulations, and duplicative staff functions. These problems could be compounded by the absence of a higher official who has direct management responsibility over both agencies who can resolve interagency disputes.

⁴³ Etheredge, Lynn. Medicare's Governance and Structure: A Proposal. *Health Affairs*, v. 19, no. 5, September/October 2000.

Prospects for the 108th Congress

At this writing, press reports indicate that the President will be forwarding a proposal to the Congress that may limit prescription drug coverage to persons who enroll in managed care plans. Congress will once again debate Medicare reform legislation; what specific action it will take can not be predicted at this point.