Medicare: What's Right? What's Wrong? What's Next?

The issue is not whether to restructure Medicare broadly, but when and how.

by Gail R. Wilensky and Joseph P. Newhouse

ABSTRACT: Although future Medicare costs are highly uncertain, reasonable projections of those costs suggest a major financing problem. The Balanced Budget Act of 1997 will provide temporary relief, although it introduced some new problems, including its geographic adjustment of Medicare+Choice rates. For the future we propose a premium-support system and an expanded benefits package. Such a system would provide a more flexible means to adjust the division of the financing burden between the elderly and the nonelderly, potentially gain some efficiencies from greater price competition and less reliance on administered pricing, and partly address the issue of uninsured early retirees.

MEDICARE REMAINS ONE OF this country's most popular social welfare programs, for good reason. Prior to its enactment, seniors had little access to group health insurance, and if they could buy individual insurance at all, it was expensive. Medicare not only provided seniors with insurance but did so on favorable terms: Today's beneficiaries have received much more from Medicare than they paid in. Not surprisingly, then, Medicare has been especially popular with the seniors it serves and also has become an important source of income for millions of providers.[1]

For most of this decade, though, there has been a growing sense that Medicare needs serious reform. The impetus for reform may have diminished temporarily as a result of the 1997 Balanced Budget Act (BBA), yet it is generally well recognized that the changes in the BBA are just the beginning.

Much of the motivation for Medicare reform has been financial: a Part A trust fund that, prior to the BBA, was set to run out of funds

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by the middle of the next decade; a rapid rate of Part B spending growth; and the looming retirement of the seventy-eight million baby boomers starting around 2010. But at least part of the drive for reform has come from the belief that Medicare should better reflect the way health care is organized and delivered in the 1990s rather than continuing to rely on the financial and organizational structures of the 1960s, when the program was conceived.

Medicare remains dominated by the traditional indemnity insurance structure that characterized the Blue Cross and Blue Shield insurance plans of the 1960s. The Blue Cross analogue is Part A, which covers inpatient hospital care, the first 100 days of home care, and 100 days of skilled nursing care following a hospital stay. It is financed by a portion of FICA, the Social Security tax on earnings. The Blue Shield analogue is Part B, which covers outpatient care, physician services, home care after 100 visits following a hospital stay or home care that does not follow a hospital stay, clinical lab services, and durable medical equipment. Unlike Part A, with its earmarked trust fund, Part B is funded by general revenues and by a monthly premium that seniors pay. The premium now pays for about 25 percent of Part B expenditures.

The Medicare benefits package also reflects the 1960s. Unlike many of today's employer-sponsored plans, Medicare does not cover outpatient pharmaceuticals, nor does it protect against very large bills. It does, however, provide 100 days of skilled nursing care following a hospital stay and unlimited home care visits, neither of which is common in employer-sponsored plans but which are clearly important to an older population.

Traditional Medicare solved the basic problem it was designed to address: providing insurance for (most) acute care for persons over age sixty-five. Moreover, seniors face few constraints on their access to individual physicians and other health care providers under traditional Medicare. Medicare represents such a large amount of revenue for providers that few turn down Medicare patients, even when its payment rates lag behind those of the private sector. Although concerns periodically arise that physicians in certain specialties or regions might be unwilling to see Medicare patients because of Medicare's lower payments, there has not been any evidence that this has been systematic or widespread.

What's Wrong With Medicare?

■ **Administered pricing systems.** Medicare's financial problems reflect some of the basic attributes that have made it so popular. Unlimited choice of providers has left a minimal role for price competition in maintaining market discipline and has forced reliance on

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administered pricing systems. It is always difficult to get administered prices "right," especially in industries (such as health care) with rapid technological change. Moreover, the structure of these systems has had powerful effects (some unintended and undesirable) on services delivered.

Shorter hospital stays and substitution of postacute care during the past fifteen years, for example, are consistent with the financial incentives of a fixed payment for a hospital admission and additional payment for nursing home days and home health visits. Lenient reimbursement for new skilled nursing, rehabilitation, and long-term hospital providers has resulted in many more such providers. Payment as a function of case-mix has offered hospitals the incentive to code patients in higher-paying categories. Some of these changes may have been beneficial, but all have largely reflected the unintended side effects of various administered-price reimbursement systems rather than deliberate decisions.

■ **Limited plan choice and Medigap.** Unlike choice among institutional and individual providers, the choice among different types of health plans under Medicare has been sharply constrained. Before the BBA the choice was effectively either traditional Medicare, which could be augmented with an indemnity insurance supplement, or the most structured type of managed care, a traditional health maintenance organization (HMO).

The restricted nature of plan choices, together with the limited nature of the benefit package, has meant that almost all seniors supplement traditional Medicare. The supplemental plan may be a retiree program, a privately purchased insurance plan designed to wrap around Medicare (an individual Medigap plan), or Medicaid. Only about 10 percent of seniors have no supplementary plans.[2]

The use of this two-tier insurance strategy rather than the use of a single (non-HMO) policy to replace all of traditional Medicare has had important consequences. For seniors, especially the half without Medicaid eligibility or employer-provided insurance, it has meant substantial supplemental premium payments. Average premiums for individual Medigap plans now range from $1,000 to $3,000 or more per year.[3]

While filling some gaps, these supplementary plans leave seniors with financial exposure for noncovered medical costs, especially those relating to chronic long-term care and, in a number of cases, prescription drugs. Moreover, the individual policies have high markups over their medical costs, typically 30 percent, whereas private group plans typically have markups of only 10 percent or less, and Medicare itself has only a 2 percent administrative cost rate.[4] Partly because of the markups in individually purchased plans,

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Medigap premiums are large relative to the income of the one-sixth or so of seniors whose only (or main) source of income is Social Security and who are not eligible for Medicaid.

Medigap creates additional costs for Medicare as well. Because Medigap fills in many of the cost-sharing requirements of Medicare, persons with supplemental plans use more Medicare-covered services and hence increase Medicare's costs. Premiums for the supplemental plans, however, do not reflect Medicare's increased costs.

Financing Medicare's Future Costs

The incentives associated with the combination of traditional Medicare plus supplementary insurance have been especially problematic, rewarding the most aggressive health care practitioners, penalizing or at least not rewarding conservatively practicing physicians, providing negligible incentives for the elderly to seek cost-effective physicians or hospitals, and providing incentives to bring onstream new technologies and procedures almost irrespective of cost.

Given these incentives, which as already noted resembled those facing persons under age sixty-five until relatively recently, it is not surprising that there has been a steady escalation of spending and that, as a result, Medicare is facing serious financial problems. From 1970 to 1997 the real growth rate of Medicare spending was about 5.4 percent per beneficiary per year, a bit higher than the 4.3 percent growth in real per person personal health care spending (about one-fifth of which is Medicare). It should not be surprising that these figures roughly correspond.[5] Historically, Medicare has given providers incentives similar to those of private insurers. Moreover, Medicare must ensure that its rates do not fall greatly below those in the private sector, to maintain access for Medicare beneficiaries. In the most recent (1993–1997) period, however, as the incentives in financing care for persons under age sixty-five moved toward managed care, these trends have diverged. The annual growth rate in real personal health care spending per person has fallen to 2.0 percent—less than half its historical value—while Medicare spending per beneficiary has fallen only slightly, to 4.7 percent.[6]

The key uncertainty in projecting future Medicare costs—and therefore the magnitude of Medicare's future financing problem—is whether the future growth rate in Medicare costs will be closer to those of the private sector in the very recent past or closer to those historical growth rates. Our guess is that the future rate will be somewhere between these two values but probably closer to the historical rate, for several reasons.

First, a considerable portion of the historical trend in overall medical spending surely reflects the increased capabilities of medi-

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"Real growth in Medicare spending after 2010 will average around 5–7 percent per year absent budget constraints."

cine.[7] Although the revolution in molecular biology may ultimately lower treatment cost, there is no certainty about this (think of the six-figure cost of Ceredase for the treatment of Gaucher's disease); in any event, "ultimately" may be well into the future. Meanwhile, the medical advances are likely to continue. To the degree that people remain willing to pay for these advances, cost growth will and should continue.

Second, to some degree the recent slowdown undoubtedly reflects one-time gains from the changeover to managed care. Although these gains might continue for several more years, we doubt that they can continue very far into the next century.

On the other hand, the spread of capitation and price competition could change the nature of medical innovation. As mentioned above, until recently the financial incentives favored any innovation that could benefit health. Cost is now more of a factor in determining whether to adopt a beneficial but more costly capability and, once adopted, how much to use it. Furthermore, the heightened sensitivity to cost may increase the rate of development of cost-saving innovations. Growth in medical spending thus may remain below historical rates, even after the one-time gains are accomplished.

Compared with these uncertainties, the consequences of demographic changes are much more certain. The Census Bureau projects that the share of the population over age sixty-five will rise from 13.3 percent in 2010, when the first wave of baby boomers turns sixty-five, to 18.5 percent in 2025. Because the total population is projected to grow 0.8 percent per year, the number of elderly will grow 3 percent per year over this period. Medicare spending would grow at roughly the same rate, absent any other change.[8] For comparison, the growing elderly population from 1950 to 2000 affected spending by only 1.7 percent per year. Our guess is that real growth in Medicare spending after 2010 will average around 5–7 percent per year, absent budget constraints or other direct limits on care. These values are considerably higher than the recent spending projections from the board of trustees of the federal Hospital Insurance (HI) trust fund. The trustees' intermediate projections assume that over the next twenty-five years the growth rate in cost per unit of service (this approximates our growth in real costs per beneficiary) will trend downward from present levels to roughly the growth rate in the economy, approximately 1 percent.[9] We agree with the trustees'

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own characterization of their estimates as optimistic; our guess is that their high cost assumption of roughly 3 percent is more likely, but it is difficult to overstate the uncertainty in all such estimates.

Even the trustees' intermediate projections imply substantial growth in Medicare spending. For example, they imply that Medicare spending will be about 6 percent of gross domestic product (GDP) by 2030, up from 2.5 percent in 1995; Part A spending will be about 6 percent of payroll, up from a base of somewhat over 3 percent in 1995; and Medicare will be over a quarter of the federal budget, up from around 11 percent in 1995.[10] Although we certainly agree with the many other analysts who have indicated the uncertainty and volatility of Medicare projections this far in the future, these numbers seem to us to be more likely low than high.[11]

A key issue, to which we return below, is how the burden of the increased costs will be shared between the nonelderly and the elderly. Under current arrangements the lion's share of the additional costs will fall on the nonelderly.

Round One Of Reform: The BBA

The 1997 BBA produced more changes in Medicare than had occurred in the thirty-plus years since the program's inception. The Congressional Research Service, among others, describes the legislation in detail.[12] Here we refer to only the most significant changes.

The BBA produced an estimated $115 billion of (net) savings over five years from Medicare spending that otherwise would have occurred under then current law. In addition, it funded several new preventive care benefits; increased the types of Medicare replacement programs available to seniors; required prospective pricing strategies to be implemented for hospital outpatient visits, home care, and skilled nursing facilities; modified the calculation of capitation rates to reduce the variation in payment across various counties; modified and delayed portions of the physician fee schedule reform; and shifted funding for a substantial share of home care visits from Part A to Part B.

■ **Short-run spending effects.** Reducing Medicare spending by $115 billion primarily slowed down the growth rate of Medicare spending during the first five-year budget cycle following enactment of the BBA. From 1997 to 2002 Medicare spending is projected to grow at a nominal growth rate of less than 6 percent per year rather than the 8.8 percent previously projected. By the 2002 to 2007 period, however, the Congressional Budget Office (CBO) projects a growth rate around 8.3 percent, only slightly less than under previous law.[13] A lower growth rate could continue if the spending freezes or reduced rates of increase specified in the BBA are contin-

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ued. However, assuming that spending growth continues in the private sector, a markedly reduced rate of growth would be difficult to sustain over the longer period without creating a substantial gap between the services enjoyed by persons under and over age sixty-five. Moreover, as expensive pharmaceutical advances continue, the pressure for some kind of drug coverage within Medicare is likely to grow—reflecting a cost not contemplated in any previous estimates. As a result, although some of the reduction in spending growth may continue after 2002, as of now Medicare spending will be growing at close to what it would have been growing without the BBA by early in the next decade.

■ **Medicare+Choice.** The BBA allowed for several new types of Medicare replacement plans under Medicare+Choice. These include a Medicare preferred provider organization (PPO); a private fee-for-service plan, which can pay physicians more than the Medicare fee schedule and can charge seniors an extra premium for the standard Medicare package of benefits; a provider-sponsored organization (PSO), in which physicians and hospitals can organize their own risk plan and compete directly with HMOs; and a medical savings account (MSA) option for a limited number of seniors, incorporating a high-deductible plan with an account set up for residual Medicare funds. The BBA also authorized the 1995 HCFA decision to allow HMOs to offer beneficiaries a point-of-service (POS) option.

The proposed rules that HCFA has released thus far indicate that the increase in actual choice may not be be as large as it appears. Some of the more loosely organized types of plans, such as PPOs, may not be able to conform to the requirements for information on quality and outcomes.[14] Since such plans have been responsible for most of the growth in managed care among persons under age sixty-five, some of the additional choices included in Medicare+Choice may be more illusory than real. Even so, the CBO is projecting a significant growth in Medicare+Choice (about half of seniors enrolled by 2030).[15]

Another important change concerns the calculation of capitation rates. Prior to the BBA, capitation rates followed the level of traditional Medicare spending per beneficiary in the county where the senior resided, adjusted for age, sex, welfare status, and institutional status. Because of differences in cost of living, health status, physician practice style, and use of medical services, per capita spending in traditional Medicare—and thus Medicare HMO rates—varied by more than a factor of three across counties.

To narrow the spread, the BBA placed a payment floor of $367 per senior per month on payments to Medicare+Choice plans; previously, payments could (in theory) have been as low as $225 per

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senior per month, and some actual payments were under $300. The floor was financed by slowing annual growth in reimbursement to HMOs in the higher-rate counties by moving toward a fifty-fifty blend of national and local rates. Rather than having actual rates decrease, however, Congress stipulated that rates in all counties would increase at least 2 percent per year. For the first few years the $367 floor and the minimum 2 percent value will be the overriding factors determining Medicare+Choice payments in each county.

Reducing variation in capitation rates has been a goal of rural coalitions and representatives of states with low Medicare spending for the past decade. However, the manner in which the BBA has reduced variation is likely to change the relationship between traditional Medicare and HMOs, with substantial unintended effects.

First, prior to the BBA, spending per senior (age- and sex-adjusted) within a county differed by only 5 percent between traditional Medicare and risk plans. Now, however, payments per senior may differ by much more within the same county. In the floor counties, for example, spending will be much higher in Medicare+Choice than in traditional Medicare. Although at-risk plans have tended to avoid such counties in the past, they now seem like inviting targets for private fee-for-service plans. By contrast, in the highest-spending counties, Medicare+Choice payments are likely to grow at much slower rates than traditional Medicare. As a result, there could be little at-risk enrollment in these counties. In all counties with spending far from the national average, vastly different amounts will be spent for what is supposedly the same package of benefits (aside from the HMO savings, which are returned to seniors as extra benefits).[16]

Thus, enrollment in traditional Medicare may plummet over time in counties with the lowest spending per capita as providers find a variety of ways to increase the funds available for their patients and themselves, in some cases without having to account for the additional benefits provided by the increased funding. Profitability for providers could be even higher, to the extent that their sickest patients remain in traditional Medicare. Comparable distortions may occur in counties with the highest spending in traditional Medicare, although here the movement would be away from capitated plans as those plans take back supplementary benefits. The 2 percent growth rates in high-spending counties will produce much less money per senior over time than what will be spent under traditional Medicare and will make it increasingly unlikely that seniors will want to participate in risk plans in areas that have the most aggressive practice styles. Both of these effects should be regarded as an undesirable and unintended consequence of reducing payment

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differentials across counties in a way that left Medicare nonneutral in the choice between the traditional plan and the other options.

Second, the BBA effectively pulls all counties toward the national mean. Although this is politically convenient, there is no compelling reason to believe that the national mean represents an appropriate spending level. Perhaps the rates in states with more conservative practice styles than the mean, such as Minnesota or Utah, should be regarded as the desired standard, and states with higher spending per capita should receive lower payments. This strategy would reduce payment even below the national mean and put pressure on providers in states with more aggressive practice styles.

Third, although the political attractiveness of increasing capitation payments in counties with low traditional Medicare spending is obvious, it will be important to monitor how the higher rates are used. With the potential availability of private fee-for-service plans and PSOs, most or all of the additional Medicare money in the "floor" counties—those raised to $367 per month—could go into higher reimbursement for providers rather than additional benefits for seniors. Because providers have been only loosely constrained under traditional Medicare, there is no strong reason to believe that the monies will translate into additional services.[17]

Finally, to the degree that health status varies across counties, some variation in payment is appropriate. For example, we know that spending is concentrated in the last year of life—indeed, 11 percent of annual Medicare spending is spent in the last month of life—and that mortality rates among the elderly vary widely among counties, probably for reasons having relatively little to do with medical care.[18] As a result, counties with higher mortality rates among persons over age sixty-five, all else equal, will have higher Medicare spending.[19] Whether a 50 percent weight on local spending will leave the right amount of variation, however, is unclear.

The BBA provides some indication of how difficult it is to introduce structural reform into Medicare. Among the many challenges are HCFA's ability to promulgate regulations in a timely way and to implement change in an orderly fashion, and Congress's ability to withstand pressure from disgruntled providers.

What Is Next For Medicare?

By buying several years of solvency for the Medicare trust funds, the

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BBA has made it possible under current law to postpone significant reform until the second half of the next decade, or later. By that time, however, the insolvency of the Part A trust fund will be upon us, and the first of the baby-boom generation will reach age sixty-five. If significant changes have not occurred by that time, the pressure to reform Medicare will become intense.

Aside from the potential political impediment of trying to reform Medicare several years before a financial crisis appears imminent, the serious substantive obstacle to such reform is that the vision of a reformed Medicare program has not been clearly articulated through the political process. Until that happens, major reform will be difficult to accomplish.

As part of the process of developing a vision, we describe some goals of a reformed program. Obviously, continuing access to health care for seniors is a given, but several other objectives also are important. These include (1) a financially stable and viable program (that is, one that does not require frequent increases in tax rates or adjustments to the base) and, in particular, some indication of how the necessary long-run financing will be structured; (2) incentives for seniors to choose efficient plans and/or providers, which implies financial incentives that reward physicians and other health care providers for providing high-quality, low-cost care; (3) choice among plans and adequate information for seniors or their fiduciaries to make informed choices; (4) a more comprehensive benefits package that partially covers outpatient drugs and in the long run covers some portion of long-term care as well; and (5) a program that is regarded as fair, to both its beneficiaries and those financing the program. A Medicare program that would meet these goals is a premium-support program, analogous to that proposed by Henry Aaron and Robert Reischauer in 1995, although our proposal differs in some respects from theirs.[20] In the remainder of this paper we flesh out our proposal.

■ **Premium support.** Seniors could choose among health plans but would receive a governmental contribution or premium support that would be largely invariant to the plan chosen. The premium support would vary, however, according to the person's age, sex, geographic area, health risk status, wealth, and use of services.

Medigap premiums are already a considerable burden for the large number of elderly who live mostly or entirely on Social Security. Because medical costs are likely to rise more rapidly than general inflation and hence more rapidly than Social Security benefits, the burden of Medigap premiums, especially for the lower-income elderly, will only worsen.[21] We assume that additional costs for this group will have to be financed largely by persons under age sixty-

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five and by higher-income elderly persons. Although the number of middle- and upper-income seniors has been limited in the past, this fortunately will not be as true for the next generation.[22]

Tying the premium-support payments to income runs the risk of undermining Medicare's political support, although as long as seniors continue to receive substantial sums from the federal government, this problem should not be insurmountable. Although some might disagree, the political dynamic that caused the repeal of the catastrophic provisions of Medicare in 1988 does not seem particularly relevant here because the changes in the catastrophic provisions were redistributive only among the elderly, with no additional financing from the nonelderly. Failing to relate premiums to income will seem even less attractive. The additional financial burden then must be shouldered either entirely by the (then relatively smaller) number of nonelderly, which also could undermine political support for the program, or by the lower-income elderly themselves, which we think is neither feasible nor desirable.[23]

Increasing government's contribution for low-income seniors while reducing it for higher-income seniors has the additional virtue of greatly restricting the scope of the separate dual-eligibility program for Medicare/Medicaid recipients and with it the incentive problem caused by the "notch" in Medicaid eligibility.[24] By creating the categories of qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs), current policy has already moved in the direction of income-related benefits.

Furthermore, the use of a premium-support program provides a more flexible way to change the Medicare eligibility age. The number of uninsured near-elderly persons has been rising under current law and presumably would do so even more under proposals that raise the eligibility age. The use of a premium-support model, however, would allow an actuarially lower contribution if persons retired before whatever age was regarded as appropriate for full benefits. Raising the age to sixty-seven but allowing for reduced payments before age sixty-five, as is now being done with Social Security, could reduce the number of uninsured.

Finally, we have already pointed out that under current arrangements almost all of the increased future costs would fall on the relatively diminished numbers of nonelderly. Combined with the increased burden of Social Security that also will fall on them, the load may be too great. If Congress wishes to reallocate some of the increased costs to the elderly, a premium-support system offers a much more flexible means for dividing the burden than do the current financing methods.

■ **The benefits package.** Historically, the relevant package of

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benefits for seniors has, de facto, included both the benefits from Medicare plus a Medigap or Medicaid package or else a Medicare replacement package offered by an HMO. In a reformed program additional benefits should be provided through the Medicare program, not through a Medigap plan. We believe that it would be unreasonable and very costly to taxpayers, however, to simply include in Medicare the benefits now covered by Medigap without assuming either that seniors continue to pay the average premium they now pay for Medigap or that a higher set of deductibles and coinsurance payments would apply. In other words, broadening the benefits package should not greatly increase the cost to government. Because of the low payouts of their Medigap policies, those who now purchase individual policies are likely to be much better off even if they have to pay the cost of the additional benefits. On the other hand, those who have retiree health benefits could have to pay more than they now do. Ideally, their present supplementary benefits would be cashed out at current value. There would be a windfall to shareholders if this did not occur.

■ **Reimbursement to plans.** Setting reimbursement rates for plans poses a variety of problems, some technical, some political, and some involving matters of equity. A persistent issue involves the choice between administratively and competitively set rates. Unfortunately, these discussions usually take place only in the context of risk plans and do not include traditional Medicare. Although setting rates competitively has clear appeal, especially to two economists, the technical difficulties in moving to this type of system should not be underestimated. It implies bidding rates in many different markets across the country and hence a set of either government or beneficiary payments that vary widely according to the competitiveness of particular markets. Moreover, with small numbers of bidders, as seems likely in most local markets, there is always the possibility of collusion against the government.

■ **Risk adjustment.** One critical technical issue, which must be effectively resolved if beneficiary choice of plans is to work well, is risk adjustment, or adjustments to premium payments to reflect expected or actual differences in health status and thus health care needs. Because spending is so concentrated among relatively few persons, not adjusting for health risk unfairly penalizes plans with a sicker-than-average population and unfairly rewards plans with a healthier-than-average population. Not making these adjustments also is an invitation to bad behavior by plans and could give new meaning to the phrase, "No good deed goes unpunished."

Risk adjustment is an issue whether one moves to a premium-support system or not, but unfortunately there remains disagree-

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ment about how best to do it. There is substantial consensus that successful risk adjustment will require encounter data, but obtaining such data in a timely, low-cost way is a challenge. The BBA requirement that the Department of Health and Human Services (HHS) issue a report to Congress on recommended strategies for risk adjustment in 1999 and implement risk adjustment based on health status in 2000 is likely to force additional thinking as well as decision making in this area.

Because of the imperfect nature of any risk-adjustment strategy in the near term and because of the potential for skimping in a fully capitated system, we think that a partial capitation system would be desirable.[25] Under such a system a portion of the government payment would reflect the capitation payment otherwise calculated, and the remaining portion would vary with actual services used. In addition to mitigating the incentives to engage in risk selection, paying plans something rather than nothing for delivering more services also reduces the incentive to skimp.

The effects of moving away from payment that is independent of use obviously depend on how far away one moves. Weights between the capitation rate and the services-used component might be on the order of seventy-five/twenty-five, but some experimentation would be required to assess the effect of various weights.[26]

■ **Consumer information.** A system of choices also requires that reliable information be presented in a clear and timely way. Work in this area is already under way because of the BBA and the move to an annual enrollment system in Medicare by 2002. The difficulties of preparing information that most seniors or their caregivers—especially the oldest old—can understand are formidable, but they do not seem insuperable. After all, seniors have been choosing among providers for decades and among Medigap plans for the past thirty years, and many have had a choice between traditional Medicare and risk plans for the past decade, all with little informational help from the government. The experience with Medigap before 1990, however, where ownership of multiple, duplicative policies was not uncommon, illustrates the potential pitfalls in this area. Moreover, implementing choice among the cognitively impaired poses obvious problems. The effort being exerted to meet this portion of the BBA requirements should improve the situation markedly, imperfect though it be.

■ **The transition.** How fast to move to the new system will depend partly on how long the nation waits to decide where it wants to go and how much (if any) infrastructure change has occurred in the interim. Much of the necessary infrastructure for a premium-support system will develop over the next decade as a

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result of changes already included in the BBA. The constraint in moving to such a system therefore may be as much political as technical. One possibility would be to enroll those becoming eligible for Medicare after a certain date, say 2002 or 2005, in a new system. How rapidly to move existing seniors to a new system is more difficult. One approach would be to move gradually up the age distribution, although perhaps not beyond a certain age for those now eligible.

WHATEVER THE MERITS or demerits of this particular proposal, a strategy of standing pat is unlikely to succeed. Although muddling through could well work for another decade or so, the magnitude of the likely fiscal problems after 2010 means that modest tinkering with Medicare as we have known it is unlikely to succeed.

The views expressed here are those of the authors and not necessarily those of the Medicare Payment Advisory Commission (MedPAC).

NOTES

1. R.J. Blendon et al., "The Public's View of the Future of Medicare," *Journal of the American Medical Association* (22/29 November 1995): 1645–1648; and R.J. Blendon et al., "Voters and Health Care in the 1996 Election," *Journal of the American Medical Association* (16 April 1997): 1253–1258.
2. Physician Payment Review Commission, *Annual Report to Congress, 1997* (Washington: PPRC, 1997).
3. *Consumer Reports* (September 1998): 34–38.
4. Some discussions seem to assume, absurdly, that any positive rate of administrative expense is excessive. The current Medicare program might obtain greater value if its administrative expenses were higher.
5. This comparison is only intended as a rough guide. Personal health care spending has a different composition than Medicare; for example, it includes outpatient prescription drugs, chronic long-term care services, and dental care.
6. Authors' calculations from data in K.R. Levit et al., "National Health Expeditures, 1996," *Health Care Financing Review* (Fall 1997): 161–200; K.R. Levit et al., "National Health Expenditures in 1997: More Slow Growth," *Health Affairs* (November/December 1998): 99–110; National Center for Health Statistics, *Health, United States, 1998* (Hyattsville, Md.: NCHS, July 1998); and *Economic Report of the President, 1998* (Washington: U.S. Government Printing Office, February 1998). Chain-weighted GDP deflator used to convert to real dollars.
7. J.P. Newhouse, "An Iconoclastic View of Cost Containment," *Health Affairs* (Supplement 1993): 152–171.
8. We have ignored the effects of differences in the age distribution within the over-age-sixty-five group, which, with the growth of the oldest old, will tend to make our calculations conservative. In 1994 the average amount per person served was $4,000 for those ages sixty-five to seventy-four, $5,400 for those ages seventy-five to eighty-four, and $6,300 for those age eighty-five and older. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1996*, 210. Also, our calculations assume that the disability and end-stage renal disease (ESRD) portions of the program maintain their current share of roughly 15

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percent of total spending, but our calculations are not sensitive to moderate errors in that assumption. For more complete discussion of the effect of demographics, see D. McKusick, "Demographic Issues in Medicare Reform," *Health Affairs* (January/February 1999): 194–207.

9. Specifically, the trustees assume that growth in Part A will trend down to growth in real earnings (0.9 percent) and that growth in Part B will trend down to the growth rate in gross domestic product (1.3 percent).
10. Calculated from Table III.B.1 (page 78) and Table I.F.1 (page 13) of the 1998 Trustees Report on the Hospital Insurance Trust Fund. We assume that the federal budget as a share of GDP remains at 21 percent.
11. See, for example, H. Aaron and R. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs* (Winter 1995): 8–30; and J. White, "Uses and Abuses of Long-Term Medicare Cost Estimates," *Health Affairs* (January/February 1999): 63–79.
12. J. O'Sullivan et al., "Medicare Provisions in the Balanced Budget Act of 1997 (P.L. 105-33)" (Washington: Congressional Research Service, 18 August 1997).
13. U.S. Congress, Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1999–2008* (Washington: CBO, January 1998), 123.
14. Medicare Program, Establishment of the Medicare Choice Program, 63 *Federal Register* 34968 (26 June 1998).
15. CBO, *The Economic and Budget Outlook*, 125.
16. This assumes that the (nominal) rate of spending increase considerably exceeds the 2 percent minimum guaranteed to all counties.
17. Although additional providers may well be attracted to areas with low payment rates, it is not clear that the number of providers is constraining services below appropriate levels.
18. J.D. Lubitz and G.F. Riley, "Trends in Medicare Payments in the Last Year of Life," *New England Journal of Medicine* (15 April 1993): 1092–1096.
19. Indeed, variation in mortality rates at the state level for the fifteen leading causes of death explains 40 percent of the variation in standardized costs per enrollee. See Prospective Payment Assessment Commission, "State Variation in the Resource Costs of Treating Aged Medicare Beneficiaries," Intramural Report no. I-96-01 (Washington: ProPAC, 19 June 1996), 19–21.
20. Aaron and Reischauer, "The Medicare Reform Debate."
21. This is also true, of course, for Part B premiums, to the degree that the federal share remains constant.
22. CBO, *Baby Boomers in Retirement: An Early Perspective* (Washington: CBO, September 1993).
23. Workers per beneficiary will fall from around 3.4 today to 2.0 in 2030, using the intermediate projections of the Medicare trustees.
24. The "notch" occurs when an additional dollar of income renders a person ineligible for Medicaid, thereby creating much more than a 100 percent tax on that dollar. In the near term the dual-eligible program would be eliminated only for those acute care costs covered by Medicare, but in the longer term it would be desirable to integrate financing for long-term care with Medicare. The expansion of home health care benefits in the 1990s has effectively begun to provide some chronic care benefits through Medicare.
25. See J.P. Newhouse, M.B. Buntin, and J.D. Chapman, "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs* (September/October 1997): 26–43; and J.P. Newhouse, "Risk Adjustment: Where Are We Now?" *Inquiry* (Summer 1998): 122–131.
26. See E. Keeler, G.M. Carter, and J.P. Newhouse, "A Model of the Impact of Reimbursement Schemes on Health Plan Choice," *Journal of Health Economics* (June 1998): 219–240, for some supportive evidence.

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