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Chapter 6

Long-Term Prospects for Medicare and the Delivery of Retiree Health Benefits

Mark V. Pauly

This chapter presents the challenges in planning health care benefits in retirement posed by the necessity to coordinate those same benefits with Medicare coverage and by the likelihood that the form, extent, and eligibility for coverage provided through the compulsory public Medicare program will change over the long term.¹ The exercise necessarily involves some projection, although not formal estimation, of future Medicare coverage and benefit payments. Predicting that future requires three assumptions. One assumption involves demographics, the rate at which populations grow at different ages and the likely incidence and prevalence of disease among these groups. It is relatively easy to predict future changes in this factor. The second assumption involves the level and rate of change of medical costs or technology. This factor is more difficult to predict, although the annual growth in real health care spending per capita in the United States has moved within a relatively narrow band of four to five percent over decades. The third assumption is the most problematic: What will future Medicare benefit packages include? Will health care reform eliminate Medicare as a separate program and will it, potentially, substitute other kinds of public or mandated coverage for people who retire before the current age of Medicare eligibility? Indeed, one key question is whether long-term prospects of private retiree health benefits will need to be examined.

This chapter posits that private retiree health insurance will continue in the foreseeable future. The basis for this idea is built on projections for Medicare as embodied in current law. The main purpose, however, is to investigate alternative strategies for Medicare and then relate them to the form of health care reform and to private decisions related to retiree

benefits. It is difficult enough, as economists and actuaries know all too well, to predict future medical costs with precision; as noted already, however, it is not that difficult to make a rough guess. Predicting what outcomes will arise from an economic system, even one as complex and atypical as the market for medical care, is child's play compared to predicting what the political process will yield over more than thirty-five years.

Indeed, the Clinton health reform package, initially proposed at the end of September, 1993, has (as of this writing) already been modified in important ways. It seems reasonable, therefore, to consider strategies alternative to those in the current Clinton proposal since modifications are virtually certain to continue to be possible.

This chapter also describes possible options for Medicare, without purporting to predict that Medicare policy will move in a particular way. At times, the temptation is to declare what may happen, or, more to the point, what is preferred for Medicare, but the task here is simply to discuss the rationale behind various models of Medicare care reform. It then will be left to the reader to estimate the length of time it will take before policy change is adopted.

Current Cost Projections for Medicare

It has become clear that something must change with Medicare because the current benefit and tax structure for Medicare is no longer fiscally sustainable. Medicare policy needs to be changed from its current form, either in terms of coverage or in terms of Medicare financing, because the Medicare Part A trust fund will be drawn down to zero within the next decade under current law. In addition, the retiree premium for Part B coverage is likely to skyrocket. Once again, the fundamental conclusion is that Medicare has to change.

The part of current Medicare coverage in which the time bomb can be heard ticking and in which the clock is easily observable, is Part A, the section that pays for inpatient hospital bills. Medicare Part A is financed by payroll taxes imposed directly on employees and on the employer's payroll expenditures. These tax receipts then go into a trust fund. At the end of fiscal 1992, the trust fund for Part A had a balance of \$121 billion. As Table 6.1 shows, however, the Congressional Budget Office (CBO) expects that balance to erode very rapidly, beginning in fiscal year 1995. Detailed estimates on the components of spending are not available beyond 1998, but the CBO and the actuaries of the Health Care Financing Administration (HCFA) predict that, given current law, the trust fund will be exhausted by approximately the year 2000.

The accounting basis for the problem is simple enough. Ever since the last attempt to "cure" the problem of Part A by raising tax rates, rev-

TABLE 6.1 Medicare Trust Fund: Part A^a

<i>Outlays by Fiscal Year, in Billions of Dollars</i>	1992	1993	1994	1995	1996	1997	1998
<i>Part A: Hospital Insurance (HI)</i>							
A. Total HI Outlays	82	91.2	102.4	113.8	125.2	138.8	148.6
Annual Growth Rate		11.3%	12.3%	11.2%	10.0%	9.2%	8.7%
Hospitals	68.9	74.4	81.6	89.8	98.4	107.5	116.9
Annual Growth Rate		7.8%	9.7%	10.0%	9.8%	9.2%	8.7%
PPS Hospitals	59.5	63.6	69.3	75.8	82	88.6	94.9
PPS External Hospitals	9.4	10.7	12.3	14.1	18.4	19	22
Hospices	0.8	1	1.2	1.4	1.8	1.8	2
Annual Growth Rate		21.9%	19.8%	17.8%	14.9%	13.8%	14.0%
Home Health	7.1	9.8	12.4	14.7	16.7	18.5	20.2
Annual Growth Rate		37.8%	27.2%	18.7%	13.9%	11.0%	9.3%
Skilled Nursing Facilities	3.7	4.7	5.7	6.4	6.9	7.4	7.9
Annual Growth Rate		28.5%	20.1%	12.8%	8.4%	6.8%	6.4%
Other Part A:	0.3	0.2	0.3	0.2	0.2	0.2	0.2
Annual Growth Rate		-19.8%	0.9%	-2.7%	-2.8%	-9.7%	0.0%
Administration (Subject to Appropriation)	1.2	1.2	1.3	1.3	1.4	1.4	1.5
Annual Growth Rate		2.9%	5.0%	4.0%	4.5%	4.0%	3.9%
<i>B. General Part A Information</i>							
Indirect Teaching Payments	3.2	3.4	3.7	4	4.4	4.7	8
Direct Medical							
Education Payments	1.3	1.3	1.3	1.3	1.5	1.5	1.5
Disproportionate Share Payments	2.3	2.4	2.6	2.9	3.1	3.4	3.8
Inpatient Capital Payments	7.2	8.2	9.2	10.3	11.4	12.5	13.8
HI Trust Fund Income	92.9	98	101.8	106.6	111	114.2	116.8
HI Trust Fund Surplus	10.9	6.8	-0.8	-7.2	-14.2	-22.5	-31.8
HI Trust Fund Balance EOY	120.6	127.4	126.7	119.5	105.2	82.7	50.8
<i>Other Part A Data:</i>							
HI Deductible in CY \$	\$862	\$876	\$712	\$752	\$792	\$832	\$872
Part A FY Enrollment (in millions)	34.4	35.1	38.8	36.4	37	37.5	38
PPS Market Basket Increase FY%	4.4%	4.1%	4.1%	4.2%	4.1%	4.0%	3.8%
PPS Update Factor (avg.)	3.0%	2.3%	4.3%	4.5%	4.1%	4.0%	3.8%
Monthly Premium in CY \$	\$192	\$221	\$243	\$256	\$288	\$310	\$333
Premium Receipts	0.4	0.6	0.7	0.7	0.8	0.9	0.9

^aSource: Congressional Budget Office. Human Resources Cost Estimation Unit. Budget Analysis Division, 1993.

TABLE 6.2 Medicare Trust Fund: Part B^a

<i>Outlays by Fiscal Year, in Billions of Dollars</i>	<i>1992</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>
<i>Part B: Supplementary Medical Insurance (SMI)</i>							
A. Total SMI Outlays	50.3	58	57.3	77.7	88.5	100.3	113.4
Annual Growth Rate		15.4%	16.0%	15.4%	14.0%	13.3%	13.0%
Physicians	26.7	31.4	36.6	41.9	46.7	51.8	57.2
Annual Growth Rate		9.4%	15.8%	14.4%	11.5%	10.8%	10.5%
DME and P&O Suppliers	1.7	2	2.3	2.6	2.8	3.3	3.8
Annual Growth Rate		14.4%	13.2%	13.8%	14.1%	14.1%	14.0%
Laboratories (Independent) ^b	1.5	1.8	2.2	2.7	3.4	4.1	5
Annual Growth Rate		17.8%	22.7%	23.0%	22.8%	22.8%	22.4%
Outpatient Hospital	10.6	12.4	14.8	17.4	20.5	24	27.9
Annual Growth Rate		16.7%	18.0%	18.8%	18.4%	18.9%	16.1%
Group Practice Plans and HMOs	3.8	4.5	5.4	6.5	7.7	9.2	10.8
Annual Growth Rate		19.8%	20.8%	19.4%	18.9%	18.8%	18.2%
Other Part B: Administration	2.3	4.3	4.4	4.8	5.4	6	6.6
(Subject to Appropriation)	1.7	1.6	1.7	1.8	1.9	1.9	2.0
Annual Growth Rate		-2.3	5.2%	4.5%	4.2%	4.0%	3.3%
B. General Part B Information							
SMI Deductibles (In Dollars)	\$100	\$100	\$100	\$100	\$100	\$100	\$100
MEI Update							
(Calendar Year)	3.1%	2.7%	2.6%	2.7%	2.8%	2.8%	2.8%
Physician Update							
(Calendar Year)	1.9%	1.4%	8.9%	1.6%	0.3%	-0.1%	-0.2%
Laboratory Update							
(Calendar Year)	2.0%	2.0%	3.0%	2.7%	2.7%	2.7%	2.8%
DME Update							
(Calendar Year)	2.3%	3.1%	2.9%	2.7%	2.7%	2.7%	2.7%
C. Premium Information							
Monthly Premium							
(In Dollars)	\$31.80	\$36.50	\$41.10	\$46.10	\$47.30	\$48.60	\$50.00
Premium Receipts	12.7	14.6	16.8	19.1	20.3	21.1	22
FY Enrollment							
(In Millions)	33.6	34.3	34.9	35.6	36	36.6	36.9
Total Medicare Disbursements	132.3	149.2	186.7	191.5	213.8	237.1	262
Total Function 570 – Medicare (Disbursement Net of Premiums)	119.1	134.1	152.3	171.6	192.6	215.1	238.1

^aSource: Congressional Budget Office, Human Resources Cost Estimation Unit, Budget Analysis Division, 1993.^bLaboratory services are also provided by physicians and outpatient hospitals. Spending for these services is included in the appropriate provider category.

enues collected at those tax rates have grown less rapidly than outlays. Indeed, in the CBO projections, outlays are forecasted to grow at 11 percent per year and revenues at only 6 percent. The fundamental message is simple and straightforward but difficult to accept. Either the rate of growth of outlays in Part A must be slowed to approximately the rate of growth in covered payrolls, or the country is in for a neverending pattern of increases in the Part A tax rate. The most important driving force behind the growth of expenditures is not the growth in enrollment, nor is it the shift in the age composition of Medicare beneficiaries toward older ages; instead, it is the growth in the benefits per beneficiary of a given age.

Are there any messages from the patterns of growth in revenues that might be used to suggest probable future Medicare Part A policy? Probably the most interesting piece of information in Table 6.1 is the projection that the largest single item of Part A expenditures, payments for hospital care, will grow least rapidly. Although their growth rate still exceeds that of trust fund income, hospital outlays for inpatient care in some years grow at rates that closely approximate the rate of growth in income. Moreover, as noted at the bottom of Table 6.1, the increase in Part A payments related to higher payments per unit of hospital care, as measured by the Prospective Payment System (PPS) market basket, generally is lower than outlays. Because the effect of enrollment growth and demographic change alone add about 2 percent per year to Medicare outlays, it follows that if no change had occurred in the volume or composition of Part A services, then fiscal stability could have been achieved, or nearly so.

There has been growth, however, in the volume of admissions for people over 65 years old and a shift in the mix of admissions toward more expensive diagnosis groups. The net impact of this shift is to cause hospital inpatient spending to grow somewhat more rapidly than trust fund income. Table 6.1 contains another important message. The growth of nonhospital-inpatient services has greatly influenced the increase in Part A outlays. In particular, rapid growth in benefits for home health care and skilled nursing facilities has fueled about one half the excess of growth in outlays over income. That growth in those two benefits doubtless was caused in part by relaxing restrictions and increasing the generosity of those benefits, as dictated by Congress. It is not just the change in benefits that accounts for this acceleration but, rather, the fact that benefits were extended to services that naturally grow at rapid rates.

Part B of Medicare is financed, for the most part, on a pay-as-you-go basis, with approximately 25 percent from premiums paid for by the elderly and about 75 percent paid for from general federal revenues. As Table 6.2 indicates, the growth rate in Part B outlays has been substan-

tially greater than that in Part A. In fact, by the year 2000, Part B outlays will be very close to Part A outlays in terms of total magnitude. All the components of Part B outlays grow rapidly, although physician expense grows least rapidly, and the largest single item of growth is that related to outpatient hospital care. In the case of these services, the difference between the addition to outlays caused by the adjustments for inflation and the rate of growth in total outlays is even more stark. As a rough approximation, growth in volume and intensity is projected to comprise about three quarters of the growth in spending per capita. Even a substantial shortfall between the caps associated with the Medicare economic index measure of input prices for doctor's services and the update permitted for physician payments is not sufficient to slow the growth in total Part B spending.²

The overall picture for Medicare Parts A and B underscores the growing need for increased income, either in the form of premiums or taxes. The Part A trust fund serves to convert a system that otherwise might have succeeded with smooth and continuous tax increases to one that is discontinuous, but the overall message is the same as in Part B: if the growth in outlays is not slowed below the projected amount, then taxes to pay for the Medicare program will have to be increased continuously and substantially.

The most recent estimate of the long-term costs implied by the provisions of current law indicates that those costs will be much higher in the first quarter of the 21st century unless the rate of growth in Medicare spending drops substantially below its long-term trend. The Technical Advisory Panel to the Advisory Council on Social Security provided estimates of the equivalent tax burden for the two parts of Medicare and for Social Security in the year 2020. In these calculations, the Medicare Part B program is treated as if it were financed by a tax on payrolls in the same way as are Medicare Part A and Old Age Survivors and Disability Insurance (OASDI). Table 6.3 shows the estimated tax rate for several situations. For all scenarios that assume a growth in expenditure anywhere close to historical trends, that tax on earnings for Medicare and Social Security alone is substantial, and usually greater than 30 percent. The only assumption that will yield tax rates close to the current revenue is one that includes a rate of growth much lower than has ever been seen, and, implicitly, elimination of cost-increasing quality improvements in the medical services reimbursed by Medicare.

Although current Medicare policy needs no changes in the short run, at least as far as the Medicare program alone is concerned, although not necessarily in terms of the overall federal budget, eventually, change must occur in one of two aspects: Either the Medicare program must find substantial new financing or some change from the long-term trend must

occur that will reduce the rate of growth in Medicare outlays per beneficiary or the number of beneficiaries.

TABLE 6.3 Health Care Projections, 2020^a

<i>Projection</i>	<i>Real Growth Rate</i>	<i>Health Expenditures as % of GNP</i>	<i>OASDI and Medicare (HI and SMI) as % of Taxable Payroll in 2020</i>
1	4.7 Last 10-year trend	36	NA
2	4.3 Long-term trend	31.5	31.6
3	3.1 Significant slowing	22.7	26.5
4	1.4 Dramatic curtailment	13.7	16 ^b

^aSource: Advisory Council on Social Security. *Income Security and Health Care: Economic Implications 1991-2020: An Expert Panel Report to the Advisory Council on Social Security*. Washington, DC: December, 1991; 72, 76.

^bAuthor's estimates

Reform Options

The next section of this chapter deals with options for the so-called "Medicare reform." It is clear that Medicare cannot continue to do business as usual. But what are the options needed to avoid bankruptcy of the trust fund or the spectacular tax increases that otherwise might occur?

Raising Payroll Taxes

The most obvious option for preserving Medicare's fiscal stability is to change taxes on payrolls from the levels in current law to the higher levels needed to finance the forecasted growth in expenditure. Such a tax would have to be two-and-one half times as high as the current one and would not only create substantially higher premiums (paid by the elderly for Part B) but also general revenue taxes (for Part B).

Although it now seems impossible to finance Medicare expenditure growth entirely through payroll taxes, it is certainly possible to imagine that taxes will be increased to solve at least part of the financial problem. The most likely way to increase the tax is to remove the upper limit on earnings subject to payroll taxation. It might even be conceivable that the extra taxes collected from applying the same tax rate to earnings above the current limit could be used entirely for Medicare, rather than

for the better funded OASDI program. Such ideas already have been discussed in some political circles. President Clinton recently proposed the removal of the upper limit on Part A taxes as a method of overall deficit reduction, not specifically for trust fund solvency.

Further expansion of the base of the Medicare tax might also be considered. The tax could be extended to income from sources other than earnings, and efforts might be made to identify currently unreported wage income and taxes. A politically more attractive solution, although one that makes little economic sense, is to apply additional taxes to the employer's share of the Medicare tax, leaving the employee's share untouched. From an economic view, payroll taxes exert an influence on worker wages regardless of who pays for them, but it may be cosmetically desirable to levy the tax on the employer rather than on the employee. Finally, some increase in tax rates is not out of the question, although it would be surprising if the payroll tax would rise much above a combined rate of 17 or 18 percent.

If some other source of tax financing is to be used to underwrite current Medicare benefits, then the policymaker's favorite tax probably is a value added tax (VAT), or national sales tax. This has the advantage over the federal income tax of having fewer loop holes but, at the same time, does not tax savings or interest on savings and, therefore, does not depress economic growth to the same extent as an income tax. The real issue for the VAT is its political salability, which has been and continues to be open to serious question.

There is one other possible vehicle for justifying a tax increase. It is possible that, by adding additional benefits to the Medicare package, which, in themselves, would potentially generate support for higher taxes, the actual amount of tax increase could be greater than what would be needed to pay for the new benefits alone. For example, even with taxes just set sufficiently high enough to pay for the additional drug expenses, adding drug benefits might help solve the program's financial problems if the consumption of drugs actually causes a reduction in the cost of other Medicare services. This is theoretically possible; some drugs do have substantial "cost offsets" in terms of reduced hospitalization or use of physician services. The likelihood of substantial additional revenue being generated by this route, however, looks small.

A halfway step between raising taxes and cutting benefits is to increase the nontax portion of Medicare revenues, that is the Part B premium. There is an historical case for doing so. Originally, the split of Part B funding between premiums and general tax revenues was to be approximately equal, but the premium share eventually fell below 25 percent (because premiums were indexed to the cost of living) and has been brought back to the 25-percent level. Even a small increase in the share,

to 30 percent, is estimated by the CBO to save substantial amounts (\$30 billion over five years) (CBO 1993). There would be a higher cost for Medicaid, which picks up the Part B premium for the poor elderly. The CBO also estimates that raising the Part B premium (through an income tax surcharge) to 100 percent of costs for elderly individuals or couples with taxable incomes above \$100,000 could add another \$18 billion.

Substituting Private Benefits

A second strategy for reducing outlays is to require that private insurers or some other private payers underwrite services that otherwise would be covered by Medicare. Laws that require private insurers to be the first payer for Medicare eligibles who also get employment-based private coverage represents one example of this strategy, although the continued decline in the number of persons over age 65 who work suggests that this approach will not make a serious dent in Medicare's problems. This provision saves only about \$1 billion per year in Medicare costs (CBO 1993). Moreover, the requirement that employers be primary payers for employed Medicare beneficiaries is about to expire in late 1995.

There is one alternative, however, that could potentially make an enormous difference. It is possible to require that employers or individuals purchase Medigap-type coverage to replace some Medicare coverage. With the majority of elderly obviously willing to pay substantial amounts for Medigap supplemental coverage, it might be tempting for budget-balancers to link reductions in the scope of Medicare's benefit, especially for elderly who are not low income, to requirements or subsidies to bring about replacement funding through private Medigap policies. For example, various tax subsidies, such as tax breaks for funded retiree benefits, might be linked to a requirement that such benefits replace payments that Medicare otherwise would have made.

Linking subsidies to Medigap coverage for purchasing substitute benefits could turn out to be a bargain for the Medicare program. Such an advantage would seem to arise, however, from misperception rather than from true financial or consumer benefit. Perhaps clever design of a subsidy tied to the purchaser's willingness to cover former Medicare benefits might work.

It seems likely that such a program would be limited to the non-poor elderly and might proceed by limitations in the scope of Medicare benefits or by increases in the extent of costsharing. On the benefits side, for example, the home health benefit or the skilled nursing facility benefit might be withdrawn, but individuals could be encouraged to purchase private insurance to cover nursing home care.

It is also possible that the government might mandate that employers

purchase post-retirement Medigap policies for their current workers that are more generous than existing policies and that contain some substitute coverage. Given the current tumult over health care reform and the difficulties of proceeding with a modest program, such a mandate does not seem likely now. If employer mandates are part of reform and if they work reasonably well, there may be a demand to replace Medicare coverage for current workers with mandated employer-provided, post-retirement health benefits. From an economic viewpoint, such a mandate is equivalent to financing the substituted portion of Medicare through a head tax, because, as noted already, the incidence of employer-paid wage supplements falls on workers in the form of lower (cash) wages. The difficulty that politicians and ordinary people have in grasping this fact makes mandated employer coverage ideal for politicians bent on using a fast shuffle to solve fiscal dilemmas.

Reducing Benefits

An alternative strategy to requiring or subsidizing private substitute benefits is for Medicare simply to cut its level of benefits to retirees unilaterally, perhaps hoping that people will fill in with private coverage. Such a strategy is politically dangerous but will yield a larger net fiscal benefit.

The most subtle vehicle for cutting Medicare benefits is to raise the age at which individuals are eligible for benefits. With the passage of federal laws that prohibit forced retirement and that permit people to continue working past age 65, there is a social basis for arguing that the age for Medicare eligibility should be extended. In addition, the increase in life expectancy that has occurred since World War II has meant that the number of years for which people over 65 will collect Medicare and OASDI benefits has grown substantially. If the intent of these social insurance programs was to provide a safety net for a certain number of years before death, then the increase in life expectancy suggests that the eligibility age should be increased.

The main problem with this strategy is that, despite the changes in laws about forced retirement and despite the increases in life expectancy, the general trend has been for people to retire earlier. The fact that they could work longer has not had much of an impact on actual behavior. It seems logical then that raising the age of eligibility for Medicare would cause people to work longer, precisely because they would need to continue working to pay the health care costs that Medicare no longer would cover.

So this strategy might work to save money in the short term, but its political feasibility seems highly dubious in the long term. Raising the age of eligibility is equivalent to reducing the level of Social Security and

Medicare benefits. Most voters presumably will be sophisticated enough to see what is happening. It is unlikely that they will tolerate this reduction in benefits.

Reducing Medicare Provider Payments

The current Clinton health reform proposal envisions substantial reductions in the projected growth in Medicare (and Medicaid) spending. Much of the Medicare "savings" is to be used to pay for new prescription drugs and long-term care benefits, with a little left over to subsidize coverage for people under 65 who work for small, low-wage firms. The implicit assumptions behind this proposal are that projected levels of Medicare spending contain substantial excess payments to providers and that cutting those payments will cause providers to provide the same for less.

As of this writing, neither of these assumptions seems to be especially plausible, and no obvious empirical evidence can be applied to them. Cutting Medicare payments and simultaneously capping private spending may avoid some of the worst aspects of "Medicaidizing" Medicare, but considerable resistance toward this method of financing new benefits is likely to come from the elderly lobby.

Means Testing

An alternative way to reduce Medicare benefits to some retirees is to link the level of benefits to income and wealth, paying less generous benefits to the higher income elderly. Another strategy that appears to be different (but is not) is to tax higher income elderly to reflect the value of their Medicare benefits. Either way, this represents a devaluation of Medicare benefits.

Means testing benefits will doubtless raise opposition from the usual elderly lobbies and from those who believe that maintenance of social insurance requires uniformity of benefits (but not taxes). The fear is that, by reducing the value of Medicare benefits to high-income elderly, those elderly may cease to support the program. Although well-to-do beneficiaries are a minority among the elderly, they can be more influential politically than the average older person, because they are more likely to vote and because they probably have the education and influence to make their views felt. The intrinsic fairness of limiting Medicare benefits for higher income elderly may be persuasive to some groups.

The next type of benefit limitation is a formal means testing of Medicare benefits. In this scenario, the size of out-of-pocket payments would be related to income, with low-income elderly receiving free care and high-income elderly facing deductibles and, perhaps, with coinsurance

rates substantially greater than those under present law. In principle, this mechanism could eliminate the need for Medicaid coverage of elderly people for acute care, because it would lower or eliminate deductibles and coinsurance for very poor people.

Another strategy for reducing benefit payments to retirees is to increase the level of beneficiary costsharing, either by raising the deductible in either part of Medicare or by increasing the coinsurance rate. The latter seems unlikely, but there is a real possibility of increasing the size of the Part A or Part B deductible, especially if the increase could be confined to higher income beneficiaries. Such an increase not only would have a direct effect on reducing Medicare outlays, but it also would help contain overall costs by imposing a larger share of the full price of care on beneficiaries.

The main problem with this reform is that it will be seen, correctly, as a reduction in total benefits. Consequently, it is likely that the elderly would oppose such an obvious benefit-reduction strategy. One possible alternative would be to offset higher Medicare costsharing, at least in part, by increasing the size of the Social Security pension payment. Such a shift simply would not wash but, instead, would lead to reduced total expenses because the higher out-of-pocket payment would reduce moral hazard. Even this logical approach seems implausible, at least in the current political environment.

Adding Benefits to Medicare

Paradoxically, in the context of discussing health reform and in the face of Medicare's dire financial straits, some policymakers appear to be contemplating increases in the services that Medicare covers. The two most frequently discussed additional services are coverage of prescription drugs and coverage of long-term nursing home care.

Coverage of prescription drugs seems to have two motivations. On the one hand, there is a small set of elderly people who bear substantial out-of-pocket payment for prescription drugs because Medicare fails to cover them, and their families have no Medigap coverage to take up that slack. Of course, prescription drug coverage was included in the Medicare catastrophic law, which subsequently was repealed. It is speculated that one reason for the repeal was that a powerful minority of elderly already were covered for prescription drugs under Medigap policies provided by former employers, and these people were strongly opposed to any plan that required them to pay additional taxes and receive no additional benefits. A health reform plan to pay for additional Medicare benefits that would be financed by taxes imposed on the general population rather than on the Medicare population alone might avoid this objection. On the other

hand, some politicians would seek a platform for criticizing drug company prices and product selection strategies. Without a major public insurance program that purchases these services, however, such criticism seems disembodied and not tied to any particular governmental program. If Medicare were a major buyer of prescription drugs, not only would it have a much more specific interest in controlling the price, it probably would also have the means to do so. The other possible extension of Medicare coverage would repeat an aspect of the catastrophic coverage act and would provide better coverage for hospital days in excess of the usual maximum. When hospital expenses mount to their highest levels, this gap in Medicare coverage appears to be a major deficiency.

More generally, what Medicare needs to do is to move its coverage from a late 1960s form, with emphasis on inpatient care and upper limits on coverage, to a 1990s form of major medical coverage that makes no distinction among types of medical expenses but does have catastrophic coverage. It is possible, although not guaranteed, that the value of such a rationalized Medicare benefits package might be great enough that beneficiaries would be willing to pay more than the cost of the additional benefits for the improved package. Some part of this excess payment could then be used to offset the deficit. Given present beneficiary attitudes, however, this is probably wishful thinking, unless there is a major push to sell an enhanced benefits package to middle and upper income elderly beneficiaries.

The final additional benefit that might possibly be added to Medicare is coverage for long-term nursing home care. Given the perilous state of Medicare financing, it would be impossible to support this additional benefit. The payroll tax rate required to pay for it would simply be out of the question in the near future, and the ability to finance it with general revenue taxation, given the current federal budget, seems limited at best.

Medicaid offers social insurance for nursing home care and provides universal coverage for such care, with a deductible approximately equal to the individual's wealth. For the majority of elderly who use this care and who have no dependents, such a policy may be socially optimal. It might be possible to add coverage for those few elderly who still have dependents, for whom drawing down of the beneficiary's wealth would seriously affect living standards; however, it seems unlikely that any long-term care benefits will be added to the program soon.

Overall Health Care Reform

The most current evaluation of health care reform does not look for the kind of piecemeal approaches to cost containment or rationalization of coverage that already have been discussed. Instead, it envisions a whole-

sale overhaul of the medical care finance, delivery, and production systems, with competitive managed care plans, largely in the form of health maintenance organizations (HMOs) as its centerpiece.

The first question is whether or not Medicare should be included in overall health care reform. The answer always turns on issues of practicality, not principle. Except for proposals that envision "Medicare for all," most strategies do not incorporate Medicare explicitly into their health care reform. In most cases, the view is that, eventually, the financing and delivery of care for people over age 65 will need to become an intrinsic part of a reform system, but the reasons are good for postponing full-scale integration until after health care reform is implemented for people under age 65.³

The reasons for postponing the integration of Medicare are based in part on the observation that universal coverage (98% or greater) has been achieved for the elderly, and that, fears about costshifting aside, the tools are in place for the government to cap or control its outlays for Parts A and B of Medicare as it wishes. The primary tool, of course, is governmental control over the annual update in both systems. There is still some leakage in terms of cost containment, primarily because hospital outpatient care is still partially paid on a cost-reimbursement basis, but the general conclusion is that Medicare already has achieved universal coverage and needs little additional structure to achieve cost containment.

Another practical reason for postponing the incorporation of Medicare is simply that the task of health reform for the under-65 population will be difficult enough without tackling a system that is not broken enough to require immediate fixing. The power and sensitivity of the elderly lobby suggest to many politicians already scared off by the Medicare catastrophic coverage debacle that Medicare reform is a fight that would best be postponed.

Despite the desire to leave Medicare out of the first round of health care reform, some aspects of reform will necessarily impinge on the Medicare program, especially the impact of Medicare expenditure limits on prices in the non-Medicare sector, and vice versa. To take a specific example, the short-run desire of policymakers who are distressed by the contribution that rising Medicare spending adds to the federal budget deficit, regardless of how much of that increase was caused by fairly recent additions to the benefits package, might be expected to take as the first line of attack the limiting (i.e., capping) or controlling of growth in federal outlays, without tampering with the private sector. Fundamentally, it would seem plausible to argue that the government should reform that part of health care for which it already has been responsible, that is, health care for the categorically eligible poor and the elderly, be-

fore it tackles the problems endemic to the rest of the population. It might be argued that the government should follow Voltaire's advice and clean up its own backyard before moving on to relandscape the rest of the world.

The main impediment to limiting initial health care reform to those areas in which the government already has a major responsibility is the fear that spillover from Medicare policy will invade the private sector. In particular, there is a strong belief that successful attempts by Medicare to hold down the unit prices that it pays for services or its total expenditures will inflate prices and costs for private sector patients. Most policymakers believe that costshifting indeed will occur, and that, therefore, they will be blamed by voters if Medicare costs are controlled. The implication is that, to control Medicare costs successfully, government needs to get its arms around the entire system.

The curious feature of this discussion is that strong reason exists to believe that costshifting may not be that important, and that the empirical evidence for its existence is not very strong. The theory behind this is well known, at least among health economists: if a health care provider sells in two markets, a Medicare market and a non-Medicare market, and if Medicare then reduces the price it pays, then the response of a provider who initially was maximizing profit should be to leave the private price unchanged or *reduce* it. The intuition is that, if the firm already had set the price to private sector patients that maximized its profits, then a reduced price from Medicare would not cause the private sector price (that already maximizes profits from existing levels of private sector business) to change. Moreover, if the lower price for Medicare patients causes the profit maximizing provider to replace them with private sector patients, then the vehicle for attracting more private patients is to reduce the price to them, either by reducing the price that people pay out-of-pocket or by offering a discount to managed care plans (to channel more private sector patients the provider's way).

The only scenario in which costshifting can occur under this logic is if the provider initially was not maximizing profits. The irony, then, is that costshifting, far from being the response of greedy providers to valiant attempts by the government to reduce the burden of health care costs on society, proves that providers had previously been generous to consumers in not taking the maximum payment available. At a minimum, this discussion would seem to imply that, if costshifting happens, it is much more likely to occur among not-for-profit hospitals—which, arguably, may not have been setting the profit maximizing price—than among physicians, who have less explicit reason to set a price below the level that maximizes their net incomes.

The most important practical observation on the issue of costshifting,

if it indeed is a real phenomenon, is that steps obviously could be taken, short of wholesale health care reform, to prevent or inhibit it. For instance, Medicare could be forbidden to pay below-cost prices to health care providers; the Baucus Amendment places such a limit (although one difficult to interpret) on Medicaid. The other observation is that, as aggressive competition by health care plans spreads, it will become increasingly difficult for providers to respond to lower Medicare payments by costshifting. To be blunt, HMOs will not tolerate it.

But if costshifting is impossible, then that offers little reassurance that cutting Medicare expenditures can be done appropriately in isolation. If providers cannot costshift, they either will lose money and go out of business or they will have to cut some aspect of care, either quantity or, more likely, quality, to fit their costs within the limits of the revenues furnished for Medicare patients.

Exit of some hospitals and, perhaps, some physician specialists ought not be cause for concern; it is the real world manifestation of the belief that the bloated health care sector must be shrunk. If it is to shrink, then some suppliers must leave. A more serious dilemma for Medicare is that, if providers do choose to tailor what Medicare patients get against what Medicare pays, then a distinction may arise in the quality of care or access to care between what Medicare patients receive and what people insured in the private sector receive. Such a distinction is unsightly and unseemly as far as politicians are concerned, and they may wish to avoid the "Medicaidization" of Medicare by forbidding the private sector from furnishing a class of medicine higher than that which the government budget cares to allot for the Medicare program.

These observations suggest that it would be difficult to limit health care reform to Medicare alone. There is no doubt that the need to control Medicare expenditures is more pressing in light of the government's fiscal problem than the need to help Fortune 500 firms who cannot control their own health benefits or cover their non-poor uninsured. It would not be surprising then that control of Medicare would be the first, rather than the last, step to health care reform.

Now, change perspective and assume that health care reform for people under age 65 will come first. There are reasons then to believe that it may be difficult to leave Medicare out. Those reasons often have more to do with politics, however, than with economics. The most prominent argument for a spillover arises in connection with the standard benefits package given to people under age 65 in a reformed health care system. It has become accepted that a uniform benefits package needs to be offered to all persons, regardless of income or need. In addition, although this sentiment is not universal, some policymakers believe that the package should contain minimal to zero costsharing by patients, and, almost

surely, not at the level of costsharing embodied in the current Medicare program.

On its face, this implies that the benefit package that citizens may be mandated to buy under health care reform will tend to look more generous than the current Medicare program. The mandated package surely will include some coverage for prescription drugs, which Medicare currently does not, and might even include coverage of long-term care for the non-elderly, if only because the cost of such coverage for younger people who are at a lower risk of needing chronic care is a relative bargain. Then the political dynamic forces consideration of the question, "Why, if drug and long-term care coverage are right for people under age 65, should they not be added to Medicare?" Moreover, as already noted, there is a strong, independent demand to add these coverages to the Medicare program, despite the virtual impossibility of financing them under any plausible modification of the current Medicare tax and transfer structure.

Attempts to reconcile Medicare and private sector health benefit packages under the rubric of health care reform could impact private retiree benefits, the most obvious being the fact that many group Medigap policies already cover prescription drugs. If such coverage were added to Medicare it no longer would be required or needed in the supplemental policy. As already noted, politicians will be sorely tempted to require those retirees who currently have insurance coverage for drugs to continue to pay for that coverage, or to have their employers continue to pay for it, rather than shift the cost to government. The possible elimination of serious costsharing in a generally mandated package might also spill over to Medicare, although the fiscal burden of having Medicaid pay for at least the deductibles and coinsurance would seem to impede any rapid shift.

The other aspect of health care reform that could have profound consequences on Medicare and, therefore, on private insurance benefits for retirees is the overall push to managed competition. Elaborate schemes in which employers (in firms below a certain size) are required to process their employees' insurance coverage through a local health insurance purchasing cooperative (HIPC) have been developed with the primary intent of inducing almost all Americans to purchase managed care or HMO-type coverage as health insurance, while, at the same time, taking away from the firm the decision about choice of plan and lodging it with the HIPC and, to some extent, with the individual worker in a multiple-choice, limited-options setting.

Although the availability of a managed care option for Medicare beneficiaries has been present for years, it has not been very popular. The key question here is whether health care reform that relies heavily on a

managed competition structure will not force the elderly to obtain insurance in the same fashion. Changes could come on either (or both) of two fronts. First, the government could pick up and change its basic Medicare benefit, requiring that it take the form of choice among a set of managed care plans or options, possibly with a point of service option. The main impediment here is that, for more than twenty-five years, the government has run the Medicare insurance plan, and turning that responsibility over to private HMOs would create a substantial upheaval. But, surely, requirements and pressure will come about to coordinate the HMO option under Medicare with the "accountable health partnerships" that the HPCs select for the under-65 population. In part, this coordination will result from the bureaucratic desire for tidiness in structural arrangements, and, in part, it will result from a need to permit those persons under age 65 who select and come to love a particular AHP to continue coverage with that plan when they become Medicare eligible. The other front concerns employer-provided health benefits for retirees. The logic here is that, if employers below a certain size are mandated to funnel health coverage for people under age 65 through the HPC/AHP vehicle, should not the same mandate be extended to retirees? Almost surely the use of this new mechanism will be required for early retirees. Exactly how it might be coordinated with employer and employee plans for Medigap coverage is unclear at this point, but it is likely to be a topic of intense discussion.

Finally, the overall global budget, which is likely to be included in some form or another in health care reform, surely will impinge on retiree health benefits. At a minimum, those benefits will not escape the long arm of price and spending controls. To the extent that the budget limit program takes the form of regulated or administered unit prices for providers, something that states are apparently being encouraged to pursue, retiree health benefit programs will be faced with the need to consider that the benefits they purchase will be bought from providers who are operating under price controls. The immediate impact of price controls, in the ordinary circumstance, should be to lower unit prices. Over time, controls may produce other provider and patient actions, depending on the extent of permissiveness for things like balance billing and the skill of providers and buyers in avoiding laws that forbid them from charging or paying higher prices for medical services.

To the extent that budget controls take the form of limits on insurance premiums, which seems likely, some serious design issues may complicate supplementary retiree health policies. Those benefits provided through managed care plans almost surely will be controlled primarily through limitations on the premiums charged, rather than on unit prices.

Implications of Health Care Reform for Employer Plans

Many of the probable or possible consequences of changes in the Medicare program for private insurance for retirees have already been discussed. Those changes in Medicare that envision shifting more of the burden for retiree health care costs back to the private sector have obvious implications. Among the possible changes in Medicare, increasing the age of eligibility or means-testing Medicare would seem to have the most dramatic financial impact on private plans—either those plans provided by employers or those paid for by retirees. As a sweeping generalization, it seems reasonable to anticipate that future changes in Medicare will require that the private sector assume more of the responsibility for payment of retiree health care benefits, either to the employer, when the workers are still employed—which really means the workers pay in the form of lower cash wages—or to retirees with some command over income and wealth when they retire.

In addition to the obligation to pay, there is likely to be more federal control over the content and design of coverage for retiree benefits. The movement to managed competition, if it becomes reality, entails a wholesale reorganization of the way in which health care is provided and the places in which decisions about benefits and rationing rules are made. Particularly as a result of health care reform, employers and individual citizens are likely to find more government limitation on their ability to choose whether or not they want to purchase health benefits and what the form of those benefits is to be.

The specific consequences that changes in Medicare or that the results of health care reform will have on employer plans have already been discussed. Under some scenarios, employers will lose their role as managers of health benefits for current workers and retirees alike. Employers simply will become conduits for a portion of the insurance premium—the part taken from employees' total compensation before the paycheck is written out and transferred to a quasi-governmental organization such as a HIPC, which then will make most of the decisions that firm benefit managers traditionally made about health plan choice and levels of expenditure. Large firms still may be permitted, at least temporarily, to make some of their own choices to run or select health plans, but the support for this exemption is not likely to be permanent.

President Clinton has proposed that the governmental plan assume most of the burden of paying for early-retiree benefits, even for firms that had already agreed to do so, but the political prospects for this proposal are in question, largely because of its budgetary cost. The direction that the Clinton reforms have taken does, however, suggest that a strategy of requiring employers to bear more of the burden of retiree benefits ap-

pears less likely, at least for the moment. Paradoxically, those employers who never involved themselves in retiree health benefits before the reform will find themselves least affected, positively or negatively, by these crosscurrents.

Politics of Retiree Health Care

The speculative character of the foregoing discussion is inevitable because, at this point, the \$900 billion question regarding the outcomes of overall health care reform is still an open one. No firm definition has been offered yet of what might be a proto-proposal for various political interests to draw a bead on their target. In particular, the political interests that purport to represent retirees have been unusually quiet, so that any attempt to predict political outcomes is a gamble. Even so, it seems worthwhile to speculate on which of the foregoing elements is likely to be combined in what form at what time in the future.

It might be easier to begin by listing the things that are least likely to happen. It seems unlikely, for instance, that Medicare's future financial problems will be solved by substantial increases in taxes paid by the non-elderly; that is, by increases in the payroll tax for Part A and general revenue financing for Part B. In addition to the facts that the elderly are less likely to be poor than the rest of the population, current political trends seem to be opposed to any substantial redistribution of costs from the non-elderly to the elderly. Under the defunct Medicare catastrophic coverage act, it was explicitly assumed that the elderly would have to finance any increase in their benefits themselves. This consensus still seems to be present and is likely to extend to increases in tax rates to maintain existing benefits in the face of growing prices or growing numbers of elderly. Today's younger people expect to grow old, but there is no necessary connection between their paying more for today's elderly and what they should expect to get when they retire. Indeed, the history of Social Security and Medicare is one in which each succeeding generation gets a smaller net surplus.

The brief and tragic history of the Medicare catastrophic coverage act also hints that it will be difficult to means test Medicare taxes or benefits in order to offer new benefits or stave off cuts. The political (as opposed to the ideological) opposition for means testing comes not from those devoted to idealized social insurance but, rather, from the political opposition of well-to-do elderly, which, so far, seems the most formidable part of the elderly lobby.

The key short-run political question is whether Medicare will be incorporated wholesale into health care reform (whatever form it takes), or whether the status quo (with some slight modifications) is likely to con-

tinue at least until the trust fund really is depleted. It is likely that some modified business-as-usual format will be the short-run strategy for Medicare.

For one thing, the job of health reform is going to be extraordinarily difficult, even if it is limited only to Medicaid and the private sector. Modifying Medicare to the same extent and to the same form as envisioned for the private sector more than doubles the work, because of the larger number of catastrophic and high-risk cases among the elderly and because of the elderly lobby. For another thing, addressing the question of Medicare reform means dealing with the dilemma of adding benefits to Medicare and, thereby, worsening federal fiscal prospects. The current macro-economic policy surely wants to avoid this. Also, the Medicare system is not so badly broken yet that it cannot continue to function, with caps or limits placed on the annual update or conversion factors in Part A inpatient care and Part B physician benefits.

The possibility of costshifting to the private sector and a "Medicaidization" of Medicare in which access is reduced will cause problems, to be sure, but the drive to reduce the budget deficit will overshadow any substantive action here. There may be some cosmetic fix-ups – largely unenforceable requirements that providers continue to provide access to Medicare patients and not raise private sector prices; but the final outcome for Medicare, whatever happens to the rest of the health sector, is surely going to be a Medicare global budget.

Finally, it is possible that overall health care cost growth may slow down, with or without public global budgets, purely because economic forces finally kick in. Had it not been for the paralysis engendered by continuous discussion of health reform, employers and insurers might already have implemented more vigorous versions of devices and incentives to control new technology. There are some intriguing hints that, in some places, this already has been successful. Moreover, the economic system is not crazy; it would never permit the medical care share to rise high enough as to impoverish people. Someone or some institution would find a feasible and salable product to prevent this, especially if there is enough pressure on overall well-being. So far, this has not happened, but only because the average American is not yet miserable enough.

If Medicare were to be blended with the current strategy for health reform, as designed by the Clintons, what form would it take? To date, two aspects of that reform are apparent in the private sector that would shake up the Medicare program even more than it will change the private sector. First, employers are to be used as conduits for financing but with little or no role on benefit choice or monitoring. Second, individuals are to be permitted an opportunity to choose among various different health plans (although with a single basic benefit), and the plans are not

to be government run. The current tax-financed, government-monopoly-operated Medicare plan does not look anything like this. The dissonance between current Medicare and health reform will be even more pronounced if reform emphasizes HMOs, something that is part of managed competition but, as of now, is being disavowed by the Gore wing of administration health policy.

There could be some cosmetic adaptation of Medicare to health reform, like restructuring the Medicare HMO option by allowing beneficiaries to purchase coverage from AHPs through HIPCs. The low rate of take-up for that option suggests, however, that there will be little impact. So, in the short-run, there is a good chance that immediate changes in Medicare will be minor. But what of the long run (around the year 2000), *if* health care spending growth has not slowed by that point? In the next section, three broad, possible strategies are discussed.

Two scenarios seem unlikely. The first is that the rest of the health care system would be structured like Medicare—a government-run, tax-financed, indemnity insurance in a fee-for-service system but with administered prices and supplemental private insurance. Presently, little pressure has been brought to put the entire system in the government's hands. The second scenario is to turn over to employers (either voluntarily or by mandate) the responsibility of financing and organizing coverage for their workers after retirement as well as during the period of active work. Self-confident employers have volunteered from time to time to provide coverage to their retirees if Medicare would turn over to them what it would have spent; however, distrust of employer choices and motives, concern about the adverse labor market effects of linking insurance coverage too closely to employment at one firm, and demise of the lifetime career argue against this.

A more plausible option, first, is extension of the employer mandate/HIPC/AHP/global budget model to post-retirement coverage. In this model, the employer is only a pipeline for funding insurance, with the key decisions made by a local quasi-public body such as an HIPC, followed by decisions among HIPC-approved plans made by individuals. The foundation for support of this approach rests largely on an economic misconception: the belief that if the employer is required to turn over funds to pay for coverage, it really is the boss who pays. Economic theory and empirical research both suggest that employees ultimately pay in the form of lower real wages. So, the success of this strategy, especially if its applicability to Medicare is delayed until after its implementation for the rest of the population, depends mainly on whether voters see through the "employer-mandate" subterfuge. It depends as well on the satisfaction with the choice of plans under managed competition.

The second scenario is the bureaucratic dream version of the first.

Create HIPC's, but have them just be local field offices of a Washington commissariat. Turn the employer mandate into a real tax, with offsets or subsidies to give it at least more progressivity than the head tax implied by a simple mandate. Make the AHP's alternative and barely distinguishable versions of government-run insurance nominally contracted out to nongovernmental firms but run as closely regulated public utilities, with controlled budgets, benefits, and prices. All important decisions are to be made politically. This scenario could happen, because it is the direction in which the political process naturally flows.

Indeed, it would not be too difficult to convert the employer mandate into a payroll tax, like the Medicare Part A tax, to reconcile benefits (e.g., by requiring that all providers be paid according to a Medicare reimbursement policy). Employers might still have a more active role to play if some supplemental coverage for the non-poor survives, but this role is likely to be small.

The third and, arguably, the most preferred scenario defines a set of minimum benefits for Americans of all ages; permits the minimum required benefit to take the form of catastrophic coverage for non-poor persons of all ages; provides closed-end, refundable tax credits for those who cannot afford to pay for minimum benefits; abolishes all other tax subsidies, including the tax subsidy to employer-paid premiums, whether for current workers or retirees; and lets citizens choose whether they wish to secure the required coverage as a tie-in with their employment (and thus get the cost advantage of group insurance), whether they want to buy it on their own, or whether they want to enhance their pensions to offer a defined contribution that could be used to buy group insurance after retirement. Existing Medicare coverage could be grandfathered for current retirees, but other arrangements might permit a switch to the incentive-neutral, free-choice setting. The overall objective, as Senator Daniel Moynihan recently expressed, is to avoid economic behavior that is affected by the tax code.

This last scenario would challenge employers to choose ways of structuring workers' health insurance, before and after retirement, in ways that succeed best in the competitive labor market. For some small firms, this may mean letting employees arrange things for themselves. For larger firms, the employer may be able to lend assistance in arranging group coverage and providing information about choices under that coverage. Because medical expenses, unlike other insured losses, are likely to remain a large but uncertain share of total spending for American families, it may continue to be good employment policy for employers to help with these costs.

This approach is not in the current political cards, although there is now some talk of providing individual tax credits as the most efficient

and least distortive way to help the self-employed and employees of small firms. The best advice for employers probably is to prepare for a rational strategy under a rational plan such as the one just outlined.

Conclusion

Business as usual with regard to retiree benefits is not a viable long-term policy for Medicare, any more than it is for the private sector. No real crisis exists at the moment, however, and there is time for rational planning in the public sector and by private agents who must adapt to the public sector. Anticipating an increasingly constrained but not fundamentally altered Medicare program is probably the best short-run strategy. For the longer run, the great gamble of health reform is difficult to handicap. Within cautionary boundaries, planning for the best is probably the best planning.

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Notes

1. For purposes of discussion, the long term will be interpreted to mean the time from now until approximately the year 2030.
2. The dramatic jump in the physician update in fiscal year 1990 was part of the phase-in for the new Resource Base Relative Value Scale.
3. In contrast, most plans seek to incorporate coverage for all people into a reform strategy, either intergrating or abolishing the Medicaid program.

Commentary: Joseph R. Antos

Every discussion on the provision of health care benefits in retirement inevitably revolves around Medicare. Indeed, private health benefits for retirees consist of Medicare wrap-around policies designed to fill in the gaps now present in the government insurance program. Poised today on the brink of potentially sweeping reform of the health care system in the United States, now is a good time to reconsider the roles of Medicare and private insurance in providing for the health needs of 35 million elderly and disabled Americans.

Mark Pauly has written an interesting chapter that addresses major Medicare reform ideas in the context of broader health care reform. The range of these ideas is vast, and the issues are far from settled. Rather than discuss all the issues, this commentary will focus briefly on a few of the major themes in Pauly's chapter.

Why Reform Now?

The history of health care reform in this country is long. The vision of comprehensive health reform reaches as far back as 1945, when President Harry Truman recommended a compulsory national health insurance system similar to Medicare (but available to everyone). Although numerous proposals for health care reform have been offered over the years by the federal government and other groups, those proposals almost always have failed to lead to action. Why is *now* the time to undertake reform?

People who lack health insurance are certainly not a new phenomenon in this country. As long as health insurance has existed, there have been uninsured people. Certainly, the proportion of the population without insurance coverage has increased somewhat over the past decade. It cannot be argued, however, that correcting our health insurance prob-

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lem became more important only when the number of uninsured reached 39 million than when that number was 30 million (Levitt, Olin, and Letsch 1992).¹

Rising costs in health care represent an old problem, as Table 6.1A illustrates. Measured as a percent of gross domestic product (GDP), national health care expenditures rose by 3.4 percent annually from 1960 to 1970. This compares to an annual growth rate of 2.9 percent in the 1980s (Letsch, Lazenby, Levit, and Cowan 1992). There is little question that the problems facing our health care system have been present for decades.

TABLE 6.1A Trends in National Health Expenditures^a

<i>Year</i>	<i>Expenditures (% of GDP)</i>	<i>Annual Rate of Increase^b</i>
1960	5.3%	—
1970	7.4	3.4%
1980	9.2	2.2
1990	12.2	2.9

^aSource: Letsch SW, Lazenby HC, Levit KR, Cowan CA. National Health Expenditures, 1991. *Health Care Financing Review*, 1992; 14:(3); see Table 5.

^bThe annual rate of increase of national health expenditures (as a share of GDP) is calculated as the compound rate over each decade (i.e., 1960-1970, 1970-1980, 1980-1990).

What has changed recently is that the middle class has become more aware of the bitter realities of the American health care system. Insurers have taken steps to segment the health insurance market and to select good risks. Changing jobs or losing a job often means loss of health insurance coverage. For many workers, especially those employed in small firms, major illness can be a double-barreled tragedy. The illness itself may be physically and emotionally draining and can result in substantially higher premiums or even loss of insurance coverage for the entire small group. Competitive pressures on employers, along with recent accounting changes, have forced everyone to realize that health benefits are enormously expensive, and that retiree health benefits are substantially underfunded. Increasingly, people believe that they are not getting good value for their health expenditure dollars.

Accompanying these facts is the sobering realization by "baby boomers" that they have begun to reach the age of health vulnerability. Concerns about the health care system are no longer some abstract consideration but have become increasingly personal. Moreover, the baby-boom generation is now in a position to do something about this dilemma. If the problems are to be resolved soon, baby boomers must search for—and implement—the solutions.

The magnitude of the health care financing problems that face the

American public is illustrated in Table 6.2A. The projected increase in national health expenditures from just over \$900 billion in 1993 to almost \$16 trillion in 2030 suggests the need for policy actions that will slow the cost spiral (Burner, Waldo, and McKusick 1992).

TABLE 6.2A National Health Expenditure Projections^a

Item	1993	2000	2030
<i>National Health Expenditures</i>			
Total (\$ billions)	\$903.3	\$1739.8	\$15,969.6
Per capita amount	\$3380	\$6148	\$47,891
Percent of GDP	14.4%	18.1%	32.0%

^aSource: Burner ST, Waldo DR, McKusick DR. National Health Expenditures Projections Through 2030. *Health Care Financing Review*. 1992; 14:(1); see Table 7.

As disturbing as these statistics are, it is not well known that these official projections assume a moderation in the rate of increase in national health expenditures in the out-years. For example, for 1993 the annual increase in health expenditures is estimated to be 10.2 percent. By 2030, that rate of increase in expenditures is assumed to drop to 7.4 percent. Thus, these estimates *assume* that actions will be taken in the future to dampen the health care cost spiral.

One final comment on these projections is in order. Economists frequently observe that there is no necessary limit to the share of GDP that can be devoted to any category of expenditure, such as health care. From the current vantage point, spending 32 percent of GDP on health care in 2030 seems implausible to most people. This is no more implausible, however, than the current 14.4 percent share of GDP would have appeared to analysts in 1960, when national health expenditures consumed 5.3 percent of GDP.

Nonetheless, a practical limit to health care expenditures is fast approaching. Spending continues to rise rapidly, and complaints about inadequate insurance coverage and problems with the service delivery system are increasing just as rapidly. This is a clear indication that the country would welcome sweeping health care reform.

What About Medicare?

After decades of debate, sweeping health care reform appears to be on the horizon in the United States. In Chapter Six, Mark Pauly considers whether Medicare will be a part of that reform, and what program changes are now being analyzed by the White House and others. It is safe to say that Medicare is part of the overall health care problem in this country.

It is far less clear how Medicare will be made part of a proposed solution, at least in the near term.

Medicare's Board of Trustees recently reported that Medicare's Hospital Insurance (HI) Trust Fund is likely to be exhausted in 1999 unless policy changes are made. Over the next 25 years, the HI trust fund deficit will amount to \$1.4 trillion (in present value terms).² The fact that insolvency is only almost here, coupled with the magnitude of the deficit, illustrates the fiscal momentum behind Medicare's underfunding. To be effective, policy actions must be taken early enough to slow that momentum. Current estimates suggest that time may be running out to enact reasonable and necessary reforms to avert substantial financial dislocation in the Medicare program.³

Many changes could be made to the Medicare program to place it on a sounder financial footing and to improve the beneficiary's access to quality care. Before considering some of these policies, it is useful to re-examine the role of Medicare within the larger system. In short, must there be a separate Medicare program to provide insurance coverage for the elderly and disabled?

In 1965, the answer to this question was "Yes." The elderly, as a group, had relatively low incomes and could not obtain private health insurance. Medicare was enacted to ensure access to health insurance for people most at risk for medical expenses.

In 1993, the answer is not so obvious. Income and asset status of the elderly have improved since 1965. The insurability of the elderly is no longer in doubt as long as insurers can structure insurance appropriately and charge a fair premium. No longer must the elderly be confined to their own risk pool, subject to rules very different from those that affect the non-elderly. With the proper system of premiums and subsidies to the low-income elderly, this population could be integrated into general health insurance risk pools. Such integration could reduce, but would not eliminate, the intergenerational wealth transfer to the elderly that has been characteristic of the current Medicare program. The balance between need for medical services and ability to pay almost certainly will require that younger generations subsidize the elderly. That subsidy, however, need not continue to go to *all* elderly regardless of medical need or income insufficiency.

Substantial technical challenges are involved with establishing the structure of premiums and subsidies. Nonetheless, one goal of health reform is to create an insurance system that provides seamless coverage. A person's ability to obtain insurance coverage should not be affected adversely by a job change or by a coworker's illness. Similarly, no logical reason exists for shifting the over-65 group to a different insurance system characterized by different operating rules and different financial consequences.

Corrections should be made to the problems and inequities that face young and old alike.

Achieving comparable insurance treatment for persons in objectively comparable circumstances (with regard to income and health status, for example) could be accomplished through various different reforms, from a national insurance system to a highly decentralized system. In 1965, the Medicare program was established with the goal of improving the circumstances facing the elderly, who were clearly disadvantaged. Whether or not a separate Medicare program will be retained in any future reforms remains to be seen, but the guiding principle should be to seek equitable treatment for all.

Some Specific Medicare Policy Proposals

Mark Pauly describes a variety of proposals that have been, or could be, considered to improve the financial viability of the Medicare program. Unfortunately, there are only two ways to accomplish this goal: raise revenues or lower program expenditures.⁴ Neither approach will be universally welcomed, no matter what specific proposals may be adopted. Regrettably, as Pauly's chapter suggests, there really are no new ideas. There are, however, a fair number of bad, old ideas, specifically, those proposals that (inadvertently) create incentives for overutilization of medical services, reduce incentives for efficient production, or lead in other ways to inappropriate increases in health expenditures. Also to be avoided, if possible, are proposals that lead to inappropriate decreases in health expenditures and those that would work in theory but cannot be implemented successfully. Obviously, finding the subset of good proposals is not a simple undertaking.

It is impractical here to parse out the advantages and disadvantages of the many proposals that Pauly discusses. Instead, let the focus fall on one issue: the consequences of reducing beneficiary coinsurance on the utilization of services.

Some proposals would have the effect of reducing beneficiary coinsurance, thus eliminating a significant barrier to care for low-income individuals. Such a proposal also could reduce the financial disincentives for using medical services among the non-poor, who may already overuse services. Another approach, mentioned by Pauly, would tie reductions in Medicare benefits to a requirement that employers or individuals purchase supplementary private insurance to replace the lost Medicare coverage. This would shift the cost of care toward other payers in the system and away from Medicare. Such a proposal could have the perverse result of increasing total expenditures if it reduced high-income beneficiaries' awareness of the full cost of health care.

A recent analysis⁵ shows the importance of beneficiary coinsurance on the level and trend of health care utilization. If the coinsurance rate (as measured by the percent of national health expenditures that constitutes out-of-pocket spending) is lowered by 5 percentage points, then national health expenditures would increase in the first year by 2.2 percent. The expenditure trend would also increase, so that, in 10 years, national health expenditures would have risen by 11.7 percent. Ultimately, expenditures increase by 14.6 percent.

Medicare's history of expenditure growth and this analysis of aggregate expenditure growth suggest strongly the need for beneficiaries to maintain a fiscally healthy understanding that health care choices directly impact their other consumption choices. Although the beneficiary ultimately pays for health coverage, the "tragedy of the commons" is that the cost of one individual's overuse is not fully borne by that same individual. Insurance spreads the risks, and, therefore, the costs and, therefore, the responsibility for socially inappropriate choices. Systems must be devised that improve decisionmaking by beneficiaries, providers, insurers, and employers if health care costs are ever to come under control.

Various short-run steps could be taken to make Medicare a more rational and appropriate insurance program for the elderly and disabled. The artificial distinction between Parts A and B of Medicare could be abolished and replaced with a simpler deductible and coinsurance structure that would apply to all Medicare services. Establishing limits on the total annual and lifetime liability that faces Medicare beneficiaries remains a worthwhile idea, despite the political history of the Catastrophic Coverage Act. To be sure, some obvious gaps are apparent in Medicare coverage that also could be filled, like payment for outpatient drugs. The need for supplementary coverage, which is known to drive up costs, would diminish if limits were established on beneficiary liability and if some outpatient drugs were covered under the Medicare program. Given the potentially strong demand for new services, however, broadening of the Medicare program must proceed with caution. Facilitating the transition from employment-based insurance to the retiree health insurance system also makes sense if a separate system is retained for the elderly. No good reason can be found for why employees should not be able to remain with the provider of choice after retirement.

Conclusion

America's health care system is in crisis. Part of that crisis is the inequitable distribution of health resources among different groups in the population. Mark Pauly sees no real crisis in retiree health care at the moment, however, and feels that there is time enough for rational planning

regarding any future reform of the retiree health system.

By some standards, there may not be a real crisis for retiree health now. But the inevitable big fight that will be waged over reform will revolve around redistribution of resources, and, in this battle, the resources dedicated toward retiree benefits cannot be overlooked. Even if retiree health benefits are not explicitly modified by health care reform, any reform that occurs necessarily will change the environment in which those benefit programs operate. Implicitly or explicitly, the retiree health system will undergo a transformation along with the rest of the country.

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Notes

1. In 1980, 30.5 million Americans were uninsured. Throughout the 1980s, the number rose, finally reaching 39.6 million in 1991. (See Levit, Olin, and Letsch 1992.)

2. This compares to projected 1993 expenditures of \$91.2 billion.

3. Note the analogy between the Medicare Trustees Report and the corporation balance sheet under Financial Accounting Statement 106 (FAS 106). FAS 106 requires that firms treat the present value of future outlays for retiree health coverage as a liability, thus highlighting the private financing problem. The Medicare Trustees Report has been reporting in a similar way for the Medicare program. Nonetheless, political pressure to resolve the Medicare financing problem has not been intense. It is not clear whether FAS 106 will serve as a more effective catalyst for meaningful reforms.

4. Note that lowering program expenditures does not necessarily mean reducing benefits. If more efficient ways of providing those benefits can be found, the benefit level can be maintained.

5. This observation is based on the unpublished work of Edgar A. Peden who performed a time-series analysis of national health expenditure data for the years 1960 to 1991.