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MEDICARE CHANGES CAN COMPLEMENT HEALTH REFORM

By Paul N. Van de Water

The U.S. health care system faces well known problems: 47 million people without health insurance, rapidly rising costs that consume 16 percent of the country's economic output, and uneven quality of care. At the same time, Medicare — the federal program that provides health coverage for older Americans and persons with disabilities — confronts major financial challenges and leaves big gaps in benefit protection.

Which set of problems is more serious — those of health care in general, or those of Medicare in particular? Which one should the next President and Congress tackle first? Former HHS Secretary Tommy Thompson has recently testified that the initial focus should be on revamping Medicare.¹ This report argues that changes to Medicare, if properly designed, can complement health reform and that the two should be pursued simultaneously. Debating which is more pressing will impede progress on both fronts.

KEY FINDINGS

- System-wide reform of health care financing and delivery is key both to controlling Medicare expenditures and to slowing the growth of health care costs in the private sector.
- Trying to solve Medicare's long-term financing problems through changes in Medicare alone would merely shift costs to vulnerable elderly and disabled beneficiaries and reduce their access to health care providers.
- Medicare, however, can serve as a model for efforts to slow the growth of costs in the rest of the health care system. Policymakers should take steps to slow the growth of costs in Medicare by creating incentives for greater efficiency, rewarding quality, and eliminating excessive payments to providers and private plans. MedPAC's recommendations provide an excellent foundation for such action.
- To be sure, changes of this type to Medicare will not come close to solving the program's long-term financing problems, nor will they approach what is needed to slow the growth of health care costs in the private sector. Nevertheless, Medicare reform and health reform can complement each other, and action is needed on both fronts.

¹ John Reichard, "At Health Overhaul Hearing, the Talk Turns to Medicare," *Health Policy Week in Review*, Commonwealth Fund, May 12, 2008.

Medicare's long-term financial challenges are indeed daunting.² The Hospital Insurance Trust Fund will be depleted in 2019, at which time income will cover an estimated 78 percent of expenditures, according to the program's trustees. The Hospital Insurance program's projected shortfall averages 1.6 percent of gross domestic product over the next 75 years. Medicare's Supplementary Medical Insurance (SMI) Trust Fund pays for physician and other outpatient health services and outpatient prescription drugs. The SMI Trust Fund is always adequately financed because beneficiary premiums and general revenue contributions are set annually to cover expected costs. But, the rapid growth in costs will place increasing demands on both beneficiaries (to pay the premiums) and taxpayers (to provide the general revenues).

Medicare's financing problems stem primarily from the continuing rise in system-wide health care costs in both the private and public sectors, not from the nature of the program or the aging of the population. Medicare spending is growing rapidly for the same reasons that private health spending is growing rapidly — increases in the cost and use of medical services. For several decades, increases in Medicare costs per beneficiary have mirrored the increases in costs in the health system as a whole. Indeed, Medicare's spending rose a bit more slowly. Between 1970 and 2006, Medicare spending for each enrollee rose by 8.7 percent annually, and private health insurance spending rose by 9.7 percent per person per year.³

The similarity in growth rates between Medicare and private insurance is not surprising, because Medicare aims to provide its beneficiaries with access to the same doctors, hospitals, and services as the rest of the population. As David Walker, former Comptroller General, has emphasized, “[F]ederal health spending trends should not be viewed in isolation from the health care system as a whole. For example, Medicare and Medicaid cannot grow over the long term at a slower rate than cost in the rest of the health care system without resulting in a two-tier health care system.”⁴

Drawing out the implications of this analysis, CBO Director Peter Orszag has concluded, “Many analysts believe that significantly constraining the growth of Medicare and Medicaid over long periods of time, while maintaining broad access to health providers under these programs, can occur only in conjunction with slowing cost growth in the health care sector as a whole. Ultimately, therefore, restraining costs in Medicare and Medicaid requires restraining overall health care costs.”⁵

² Paul N. Van de Water, *Medicare Finances: Findings of the 2008 Trustees Report*, National Academy of Social Insurance, Medicare Brief No. 18, March 2008.

³ Centers for Medicare and Medicaid Services, “NHE [National Health Expenditure] Web Tables,” January 2008, available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>. The cited figures refer to benefits commonly covered by Medicare and private health insurance.

⁴ David M. Walker, “Long-Term Fiscal Issues: The Need for Social Security Reform,” Statement before the Committee on the Budget, U.S. House of Representatives, February 9, 2005, p. 18.

⁵ Peter R. Orszag, “Health Care and the Budget: Issues and Challenges for Reform,” Statement before the Committee on the Budget, United States Senate, June 21, 2007.

Medicare need not be a spectator, however, but can play an important role in the effort to slow the growth of both public and private health care costs. As the largest U.S. purchaser and regulator of health care, Medicare exerts a major influence on the rest of the health care system. As a purchaser, Medicare provides health coverage to 45 million people age 65 and over or with disabilities, or 1 out of every 7 Americans. Its reimbursement and coverage policies have been widely adopted by private insurers and other public programs. For example, many private insurers follow Medicare's lead in approving coverage of new medical technologies. Over the years, the private sector has also typically followed Medicare's lead in adopting new payment mechanisms — including the prospective payment system for hospitals and fee schedule for physicians.⁶ In its regulatory role, Medicare influences the provision of care through its conditions of participation for hospitals and health plans, reporting requirements, claims review practices, and other administrative procedures.⁷

Some touted Medicare “reforms” would merely shift costs to Medicare's elderly or disabled beneficiaries by reducing benefits, limiting eligibility, increasing deductibles and cost sharing, or even capping spending per beneficiary. This strategy has major limitations because many Medicare beneficiaries are financially vulnerable and already face substantial out-of-pocket medical costs.⁸ Most Medicare beneficiaries live in families with modest incomes. In 2004, 57 percent of Medicare's non-institutionalized beneficiaries had annual family incomes of less than \$25,000. Only 14 percent had incomes of \$50,000 or more.⁹

In contrast to proposals that would just shift costs, other changes in Medicare aim to slow the growth of costs by creating incentives for greater efficiency, rewarding quality, or eliminating excessive payments to providers and private plans. Policymakers should seek out initiatives that have the potential both to strengthen Medicare's financial status and, at the same time, serve as a model for the rest of the health care system. Examples include:

- eliminating the overpayments that Medicare is making to insurance companies that participate in Medicare Advantage (the privatized part of Medicare), as recommended by the Medicare Payment Advisory Commission (MedPAC);
- establishing a vigorous research program on the comparative effectiveness of different health care treatments and procedures, also endorsed by MedPAC;
- altering Medicare's payment systems to reward improved quality and efficiency (for example, implementing value-based purchasing¹⁰);

⁶ Rick Mayes and Robert A. Berenson, *Prospective Payment and the Shaping of U.S. Health Care* (Baltimore: Johns Hopkins University Press, 2006).

⁷ Bruce C. Vladeck, Paul N. Van de Water, and June Eichner, *Strengthening Medicare's Role in Reducing Racial and Ethnic Health Disparities* (Washington: National Academy of Social Insurance, 2006), pp. 5-6.

⁸ Edwin Park and Danilo Trisi, “Improving the Medicare Savings Programs Would Help Low-Income Seniors Cope with Higher Medical Expenses,” Center on Budget and Policy Priorities, May 20, 2008.

⁹ Data from the 2004 Medicare Current Beneficiary Survey, provided by Westat, March 21, 2008.

¹⁰ Robert A. Berenson, “Getting Serious About Excessive Medicare Spending: A Purchasing Model,” *Health Affairs, Web Exclusive*, December 10, 2003.

- promoting the use of electronic health records for Medicare beneficiaries as a means of improving communication, decreasing unnecessary services, and controlling fraud;
- requiring physicians participating in Medicare to issue prescriptions electronically;
- requiring health care providers to educate Medicare beneficiaries about alternative treatments and procedures; and
- strengthening primary care and care coordination in Medicare (for example, expanding medical homes).

Such changes to Medicare could complement comprehensive health reform. But they will not by themselves come close to solving Medicare's long-term financing problems, nor are they a substitute for efforts to achieve universal health coverage and system-wide cost containment. The Institute of Medicine has demonstrated that "the lack of health insurance for tens of millions of Americans has serious negative consequences and economic costs not only for the uninsured themselves but also for their families, the communities they live in, and the whole country."¹¹ Even many people with health insurance are experiencing serious problems paying for the rapidly rising costs of health care and health insurance.¹² Medicare reform and health reform can complement each other, and action is needed on both fronts.

¹¹ Institute of Medicine, *Insuring America's Health: Principles and Recommendations* (Washington: National Academies Press, 2004).

¹² Kaiser Family Foundation, *Survey Brief: Economic Problems Facing Families*, May 1, 2008.