

MEDICARE POLICIES

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Fiscal and Policy Issues Facing Medicare in the 21st Century

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Abstract

The Balanced Budget Act (BBA) of 1997 (P.L. 105-34) will reduce substantially the growth in federal spending between 1998 and 2002, creating approximately \$160 Billion in overall budget savings during this period. Savings from the Medicare program accounts for the largest component of these budgetary savings. As a result, the growth in Medicare spending will decrease from 8.8 percent prior to the BBA to 5.5 percent with the BBA. This landmark piece of legislation has changed the nature of the federal policy debate concerning the budget. Proposals for “spending” the budget surplus expected from the robust growth in the economy and the BBA have replaced the previous debate over the nature and extent of spending reductions.

The BBA presents a new policy baseline for discussing the long term reform of the Medicare program. This paper examines the projected growth in Medicare and its role in the federal budget through the year 2030. The analysis shows that dedicating the savings from discretionary spending and interest payments on the debt could be sufficient to finance the demographic shifts accompanying the retirement of the baby-boomers. However, the ability of policymakers to sustain the BBA savings depends on the successful implementation of several unproven, and yet to be developed, payment reforms. Thus, both the short and long-term ability of policymakers to constrain Medicare growth depends critically on several key implementation issues.

Changes in Medicare policy will impact other parts of the health care system. Policy reforms to the program need to consider these interactions, and evaluate their impact.

Failure to do so may produce welcome reforms to the Medicare program, but poor public health policies.

Fiscal and Policy Issues Facing Medicare in the 21st Century

Introduction

The Balanced Budget Act of 1997 (BBA, H.R. 2155) achieved several critical political and economic objectives. The BBA reduced the expected growth in Medicare spending by \$100 Billion between fiscal years 1998 and 2002, reducing its average annual growth from 8.8 percent to 5.5 percent between 1998 and 2002. The budget savings in Medicare and other federal spending are expected to generate a budget surplus of \$14 Billion by the year 2001 (Congressional Budget Office, 1997a). President Clinton's fiscal year 1999 budget proposal would eliminate the budget deficit two years earlier. In addition to the budget surpluses projected by the Congressional Budget Office through the ten year budget window (through 2008), Medicare savings derived from Part A of the program have extended the solvency of the Hospital Insurance (HI) trust fund to the year 2010.

The policies outlined in the BBA would, if adopted through the year 2002, address several of the short-run problems facing the federal budget as well as the Medicare program. With these shorter-term issues addressed, the debate concerning Medicare policy has shifted to intermediate and longer term issues. For instance, the BBA created a federal Medicare commission charged with examining the future course of the Medicare program. The scope of issues facing the Commission, and federal policymakers are daunting. They include crafting policy options for accommodating the expected increases in Medicare enrollment as the baby boomers retire. In addition to the demographic

challenges facing federal policymakers, issues concerning the quality of care delivered to Medicare beneficiaries and how they are best delivered will be debated. This paper examines a subset of the broad range of issues facing the Medicare program in the 21st century. I specifically focus on three related set of issues:

1. The long-term impact of Medicare on the federal budget. Growth in the number of Medicare beneficiaries driven by the baby-boomers will increase the costs of the Medicare program. What impact will these demographic changes have on the federal budget through the year 2030 and what policy options exists to mitigate the adverse effects such growth may have on the deficit?
2. Implementation issues embedded within the Medicare provisions of the BBA. The Balanced Budget Act of 1997 reduced substantially the projected growth in Medicare spending. Central to this strategy is the expansion of prospective payment systems to post-acute care benefits and the increased reliance on managed care through the Medicare+Choice program.
3. Interactions between Medicare policy changes and the private sector. How will future changes in Medicare policies designed to address the affordability of the program, and improvements in health care benefits provided beneficiaries, impact the health care delivery system? In particular, what interactions exist between Medicare policy proposals, the market for private insurance, as well as care provided to the uninsured?

II. What is the Nature of the Medicare Fiscal Crisis, And What Options Exist to Finance It?

Medicare's role in the overall federal budget provides the broadest view of the demographic challenges facing the program. Increases in Medicare (and social security) expected with the retirement of the baby-boomers would increase federal outlays, and absent other policy changes, increase the federal deficit. Rising federal debt could reduce economic growth. In addition to the long-term budgetary implications of Medicare, analysts and policymakers also monitor more narrow measures of the fiscal health of the program. For instance, the Health Care Financing Administration's Office of the Actuary calculates the financial condition of Medicare's component trust funds; the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund. The HI trust fund is financed primarily through payroll tax contributions (which contribute 89 percent of total HI income) while the SMI fund is financed through premium contributions and general revenues. Understanding the fiscal health of each fund is important¹. Under current law, the HI trust fund is projected to remain solvent until the year 2010 (Congressional Budget Office, 1998). However, relatively simple changes could be made to shore up the HI fund. For instance, one could provide additional general revenue funding, move some expenses from the HI fund to SMI, or some combination of both. In this case, the HI fund could be made fiscally solvent in perpetuity.² However, such transfers would not impact overall Medicare spending, or its economic impact on the federal budget. For this reason, my focus of attention is on the

role that Medicare spending assumes in the broader federal budget debate, rather than the more narrow constructs of each separate trust fund.

Projections of the federal budget are typically constructed assuming a budget “baseline”.

The baseline projects federal spending and outlays over a ten year budget window assuming existing public policies hold throughout the period. Current policy baseline projections are routinely estimated by the CBO as well as the Office of Management and Budget. The analysis presented builds on the budget baseline concept by extending revenue and outlay projections beyond the ten year budget window. The projections presented here are derived from recent work completed by the CBO. To illustrate the long-term budgetary implications of the Medicare program, I present two sets of projections. The first projection presents the pre-BBA current policy baseline developed by the CBO. These projections extend their ten year budget estimates through the year 2030. The longer term projections incorporate assumptions that rising debt competes with private capital, reducing the growth in real gross domestic product (GDP) per capita. The projections presented in Table 2 assume that the pre-BBA current policy baseline derived from the Medicare Trustees 1996 Annual Report and 1996 projections from the Social Security Administration. Federal receipts are projected to remain at approximately 20 percent of GDP over the projection period. Discretionary spending in the scenario is also projected to rise with inflation beyond 2007 (Congressional Budget Office, 1997). Though discretionary spending would retain its real value over time, it would decrease as a percent of GDP. This would continue its long-term reduction as a percent of GDP (see Table 1). After the Vietnam war, discretionary spending totaled 10.2 percent of GDP, it

decreased to 8.8 percent of GDP by 1990, and most recently accounted for 6.9 percent of GDP during fiscal years 1997 and 1998. Extending current law would lower discretionary spending to 4.1 percent of GDP by 2030. The analysis also assumes that other forms of mandatory spending (other than social security, Medicare and Medicaid) grow with the economy.

TABLE 1. FEDERAL DISCRETIONARY SPENDING AS PERCENT OF GROSS DOMESTIC PRODUCT, 1970 – 2030.

Year	Discretionary Spending As % GDP
1970	11.9%
1975	10.2%
1980	10.2%
1985	10.1%
1990	8.8%
1991	9.1%
1992	8.7%
1993	8.3%
1994	7.9%
1995	7.6%
1996	7.1%
1997	6.9%
1998	6.9%
2002	5.6%
2010	5.0%
2020	4.5%
2030	4.1%

Source: Office of Management and Budget and Congressional Budget Office.

The pre-BBA projections highlight the sizeable budget deficits expected to accompany the growth in Medicare (and social security) and interest payments on the debt. The extended current policy projections highlight two important results. First, under the pre-

BBA baseline projections, Medicare would rise from 3 percent to 7 percent of GDP between 2000 and 2030. Second, the persistent budget deficits, traced to rising entitlement spending projected during this period, would require higher annual outlays to service both the previous debt burden as well as the additional debt incurred each year. Both rising entitlement spending and interest payments would continually increase the federal budget deficit. This rising debt obligation would, according to the CBO projections, yield lower economic growth and higher interest rates.

TABLE 2. PRE-BALANCED BUDGET ACT PROJECTIONS OF MEDICARE, TOTAL FEDERAL SPENDING AND REVENUES AS PERCENT OF GROSS DOMESTIC PRODUCT, 2000 – 2030.

	2000	2005	2010	2015	2020	2030
Revenues	20%	20%	20%	20%	20%	20%
Spending	22%	22%	23%	25%	27%	37%
Discretionary and Other**	11%	9%	9%	9%	9%	9%
Social Security	5%	5%	5%	5%	6%	7%
Medicare	3%	4%	4%	5%	6%	7%
Medicaid	1%	2%	2%	2%	2%	3%
Net Interest	2%	2%	3%	3%	4%	12%
Net Deficit	-2%	-2%	-3%	-5%	-7%	-17%

Source: Derived from Congressional Budget Office projections (1997)

Table 3 presents the most recent CBO baseline projections covering fiscal years 1998 through 2008. These results highlight the critical importance assumed by the BBA. In short, balancing the budget primarily by slowing the growth in federal spending (spending is expected to decrease by nearly 2 percent of GDP by 2008, with revenues declining 0.6 percent of GDP over the same period), allows Medicare and social security to rise yet still generate budget surpluses! During fiscal year 1997, a \$22 Billion deficit was projected (0.3 percent of GDP). However, by 2002, total revenues would exceed total spending by 0.7 percent of GDP, and by 2008 the surplus would rise to 1 percent of GDP. Note that the move from a budget deficit to a surplus during this period occurred even as spending for Medicare increased from 2.6 % of GDP to 3.4% percent of GDP. This growth in Medicare spending as a share of the federal budget and of GDP would, under current policy, be accommodated through lower federal spending on interest payments and lower discretionary spending. Net interest payments are expected to decrease with the budget surplus. Real discretionary spending is also expected to decrease between 1998 and 2002. Beyond 2002, such spending is expected to rise with inflation. However, since inflation is expected to rise substantially slower than GDP, spending would continue to decrease as a percent of GDP through 2008.

**TABLE 3. CURRENT POLICY FEDERAL REVENUE AND SPENDING
PROJECTIONS AS PERCENT OF GROSS DOMESTIC PRODUCT, 1997 – 2008.**

	1997	2002	2008
Revenues	20.9%	20.4%	20.3%
Spending	21.2%	19.7%	19.3%
Social Security	4.5%	4.5%	4.7%
Medicare	2.6%	2.8%	3.4%
Medicaid	1.2%	1.3%	1.6%
Discretionary and Other	9.8%	8.8%	8.0%
Net Interest	3.1%	2.3%	1.5%
Net Deficit	-0.3%	0.7%	1.0%

Source: CBO (1998)

Though the ten year projections provide a useful framework for evaluating the composition of federal spending and revenues, they end before the demographic changes facing the Medicare program begin. For example, the number of Medicare beneficiaries is expected to increase from 33 million in 1996 to 46.7 million by the year 2010—a 2.3 percent annual increase. Moreover, between 2010 and 2020, the number of beneficiaries is expected to rise to 61.1 million, increasing at an average annual rate of 2.7 percent during this period. One approach for assessing the impact of these demographic changes is to extend the ten year current policy projections through the year 2030. Table 1

presented one set of such estimates using assumptions prior to the passage of the BBA. In contrast, Table 4 provides revenue and spending projections assuming the agreements reached in the BBA are extended past the year 2002. These projections would require the Congress to pass legislation limiting the growth in discretionary spending to the growth in inflation (as is current policy beyond 2002). In addition, the results in Table 4 assume that the Congress would maintain the growth in Medicare spending at the same per beneficiary rate agreed upon in the BBA—approximately 5 percent per beneficiary—between 2002 and 2030. Revenues are projected to remain at 20 percent of GDP.³

TABLE 4. PROJECTED CURRENT POLICY FEDERAL SPENDING AND REVENUES AS PERCENT OF GDP, MEDICARE GROWTH AT BALANCED BUDGET ACT PER CAPITA RATES.

	2000	2005	2010	2020	2030
Revenues	20%	20%	20%	20%	20%
Total Spending	20%	19%	19%	19%	21%
-Discretionary and other Mandatory*	9%	8%	8%	7%	7%
-Social Security	4%	5%	5%	6%	6%
-Medicare	3%	3%	3%	4%	6%
-Medicaid	1%	1%	2%	2%	2%
-Net Interest	3%	2%	1%	0.5%	0.5%
Net Deficit	0%	1%	1%	1%	-1%

Source: Derived from CBO (1997)

*Includes other mandatory spending other than Medicare, Medicaid, Social Security and interest.

The results in Table 4 present a substantially different picture of the federal budget through 2030 compared to the pre-BBA forecasts in Table 1. Assuming current policy continues past 2002, Medicare spending would rise from 3 percent of GDP in 2000, to 4 percent by 2020 and ultimately to 6 percent by 2030. The percent of GDP consumed by the Medicare program is substantially lower in the post-BBA projections compared to those presented in Table 1. Under these current law assumptions, the budget would remain in balance through 2020, reducing net interest payments from 3 percent of GDP in 2000 to approximately 1 percent of GDP by 2020. With discretionary spending retaining its real value over time, such expenditures (here combined with other mandatory spending) would continue their long-term decline as a percent of federal spending, falling from 9 percent to 7 percent of GDP between 2000 and 2020. In this scenario, even with the expected demographic changes generating spending increases in Medicare and social security, their growth could, in theory, be accommodated by the reductions in discretionary spending and net interest payments. This longer term scenario highlights precisely the same set of policy implications displayed in the ten year budget window from Table 3. With a balanced budget in place, the growth in Medicare and social security may be accommodated through reductions in federal discretionary spending and net interest payments on the debt.

By their nature, these current law projections assume the continuation of policies in place past 2002. Indeed, the only change to current law in the analysis from Table 4 is the assumption that Medicare spending per beneficiary would continue to rise at their BBA rates of growth. As a result, the projections assume that budget surpluses will not be used

to reduce taxes, or increase other forms of federal spending. If policymakers choose to reduce taxes, increase discretionary or other forms of entitlement spending, the growth in Medicare would have to fall below the rates projected in Table 4 , other forms of revenue would have to rise, or both.

The analysis presented above assumed that slower growth in discretionary spending and payments on the federal debt would be used to pay for growth in Medicare and social security. However, some policymakers will propose using these savings to achieve other policy objectives, including lower taxes, or new federal expenditures for other services (i.e. additional health care coverage for the uninsured). Moreover, policymakers may seek to improve the services currently provided by the Medicare program. The results presented in Table 4 assume no changes in the benefits currently provided through Medicare. Yet, in its current form, the Medicare program has several shortcomings. Compared to plans typically offered by employers, the Medicare benefit package is substantially less generous. Its relatively high copayments, and deductibles (in particular the hospital deductible) and in particular the absence of any limits on out-of-pocket spending differ substantially from plans in the private sector. In addition, outpatient prescription drugs are not covered under Medicare's fee-for-service package. Overall, benefits provided Medicare beneficiaries are less generous than 90 percent of the plans offered by employers (unpublished data from Department of Health and Human Services, and Actuarial Research Corporation, 1992). Thus, one issue for long-term Medicare reform is to align the Medicare set of benefits with those typically provided by employers

(see Aaron and Reischauer, 1998). Of course, providing more generous benefits will increase Medicare spending, raising the issue of how to finance such an expansion.

Other policymakers and analysts have expressed interest in assuring that Medicare spending can be financed through the same or a similar proportion of premium revenue, HI payroll tax receipts and general revenues over time. This may require an increase in the HI payroll tax. The extent of the payroll tax increase depends on when it was adopted, as well as projections concerning the long-term growth in HI and SMI spending.

Alternatively, the same objective could be achieved through further reductions in Medicare spending. The analysis presented above provides one such scenario—long term Medicare growth per beneficiary at 5 percent. This is approximately the same rate projected in the private sector. Though policies could be developed forcing spending to rise at rates below those expected in the private sector, this could jeopardize beneficiary access to providers as well as the quality of care they receive. Other means for reducing the growth in Medicare spending include increasing the age of eligibility, increasing premium contributions from higher income beneficiaries, or both. The analysis below presents these alternative policy options and estimates their impact on long-term Medicare spending.

Table 5 presents several illustrative Medicare policy proposals. In each case, I assume Medicare spending rises at the BBA rates per beneficiary. Each option either increases or reduces spending relative to this policy baseline. I present three illustrative options.

Option 1 would increase the age of Medicare eligibility to age 70 between 2003 and 2032

(CBO, 1997). The second option would improve the generosity of the Medicare benefit package, aligning it with a typical private health plan.⁴ The third option would enhance the Medicare benefit package and slowly increase the age of eligibility to 70 by the year 2032.⁵ Clearly, other policy options could achieve similar levels of spending, and levels of care to Medicare beneficiaries. The three options provide an illustrative range of options for policymakers beyond extend the BBA rates of growth beyond 2002.

TABLE 5. ILLUSTRATIVE POLICY OPTIONS FOR RESTRUCTURING THE MEDICARE PROGRAM, PROJECTED SPENDING AS PERCENT OF GROSS DOMESTIC PRODUCT, 2000 – 2030.

	2000	2005	2010	2020	2030
Medicare Spending at BBA per Beneficiary Rates	3%	3%	3%	4%	6%
Medicare Spending at BBA per Beneficiary Rates, Phased-In Medicare Eligibility To Age 70 by 2032	3%	3%	3%	4%	5%
Enhanced Medicare Benefit Package, Spending at BBA per Beneficiary Rates	3%	3%	4%	5%	7%
Enhanced Medicare Benefit Package, Spending at BBA Per Beneficiary Rates Phased-In Medicare Eligibility to Age 70 by 2032	3%	3%	4%	5%	6%

Medicare spending would rise from 3 percent of GDP today to 5 percent of GDP by 2030 if Medicare eligibility was increased to age 70 by the year 2032. According to the projections from Table 4, this lower growth in Medicare would, holding the growth in other federal spending and revenues at their BBA levels, generate a balanced budget by the year 2030. Improving the Medicare benefit package (option 2) would increase Medicare spending from 3 percent of GDP today to an estimated 7 percent of GDP by the year 2030. Note that this level of Medicare spending is approximately the same as projected in Table 1 before the BBA. However, option 2 would generate budget deficits by the year 2020, with the deficit rising to over 2 percent of GDP by the year 2030. Even at the BBA rates of growth, enhancing the Medicare benefit package will require further reductions in federal spending, additional revenue, or both.

Combining more generous benefits with an enhanced set of Medicare benefits would, by the year 2030, generate Medicare spending similar to that projected under our “baseline” rate presented in Table 4. However, as the phase-in would not be completed until 2032, Medicare spending between the year 2000 through 2020 would be higher than Medicare growth at the BBA per beneficiary rate.

The illustrative options from Table 5 present a range of choices for policymakers seeking to achieve different goals in the long-term restructuring of Medicare. Absent an increase in payroll taxes, program savings could be achieved by increasing the age of eligibility (or higher beneficiary premium payments), and maintaining the BBA growth rates. This would slow substantially the growth in Medicare spending, and allow policymakers to

devote the expected budget surplus to other federal spending, reducing taxes, or both. Alternatively, even with the extension of Medicare spending at the BBA levels, improving Medicare benefits will require an auxiliary source of revenue, or increasing beneficiary costs. Absent these changes, improving Medicare benefits would produce budget deficits as the baby-boomers retiree. Table 5 provides only one approach for financing these additional benefits--by increasing the age for Medicare eligibility.

III. Key Implementation Issues Facing Medicare Reform

As the analysis presented above highlights, the BBA has changed significantly the nature of the near and longer term debate concerning federal spending and revenues. Just two years ago, Medicare spending was projected to account for 4 percent of GDP by 2010. The BBA provides the framework for reducing Medicare spending to 3 percent of GDP. Moreover, projected budget deficits have been replaced by budget surpluses. As the results presented above reveal, even with the retirement of the baby-boomers, the extension of current law rates of growth in Medicare would, assuming current policy elsewhere, facilitate the growth in Medicare through reductions in federal outlays.

The BBA is expected to produce \$100 Billion in Medicare savings between 1998 and 2002. However, these savings are largely dependent on the successful implementation of new payment modalities, and methods of delivering services that have not been finalized. Thus, one of the major risks facing the long term Medicare savings assumed in the

analysis above is the successful implementation of the Medicare reforms enacted as part of the BBA. These savings will depend critically on the development and implementation of several new prospective payment systems for post-acute care benefits. For instance, new payment systems are slated for home health care, nursing homes, rehabilitation hospitals, and outpatient hospital care among others. Like the private sector, Medicare has also staked a large part of its future on savings generated from managed care. To date these savings have been elusive.

Perhaps the most dramatic change in the BBA is the Medicare+Choices program. Medicare+Choices expands the variety of plans available to Medicare beneficiaries. In addition to traditional health maintenance organizations, beneficiaries may now select among medical savings accounts administered by health insurers, provider-sponsored organizations, private fee-for-service plans, and preferred –provider organizations. This expanded choice of plans is expected to increase Medicare’s managed care enrollment from 15 percent during 1998 to 38 percent by 2008 (Congressional Budget Office, 1997a).

Though employers appear to generate savings from managed care, Medicare appears to spend more.⁷ One factor accounting for the different performance of managed care in the public and private sector relates to plan choice. As of 1997, over 50 percent of workers may only choose a single plan, which is generally a managed care plan (KPMG Peat Marwick, 1997).⁸ Offering a single, rather than multiple plans, reduces the need for purchases to risk adjust their payments across health plans. Medicare, in contrast, has

moved in the opposite direction. Rather than the private sector model which has restricted plan choice, Medicare has expanded the variety of managed care plans available to beneficiaries. To date, however, several features of the Medicare program limit any potential savings from managed care. First, unlike the private sector, Medicare's managed care payments are linked to the fee-for-service sector. Second, Medicare's approach for risk adjustment results in higher payments to health plans compared to what would have been paid in the fee-for-service sector.

Several changes in how Medicare structures the managed care market will be required to generate sustainable savings in the program. First, Medicare must create an environment where health plans compete for patients based on efficiency and quality of care. Second, the Medicare program needs to improve its approach for adjusting for risk. The approach does not need to be perfect, only as sophisticated as the ability of the health plans to favorably select enrollees. Third, Medicare needs to delink payments to health plans from the fee-for-service sector.

The first issue is central for establishing a climate where quality, price and satisfaction is rewarded with additional enrollment. To date, however, there is limited ability for Medicare beneficiaries to compare payments, plan satisfaction and quality, and differences in benefits across health plans. One approach for restructuring the market is to build on the model used by the Federal Employees Health Benefit Plan (FEHB). Under the FEHB, the Office of Personnel Management routinely provides detailed data on each plan regarding their premium, what benefits are covered, and the level of cost-sharing.

Supplemental data easily available through the Check Book Guide for Consumers (Francis, 1998) provides additional information, including expected out-of-pocket spending by plan. Both the government and the Check Book guide provide detailed information for nearly all plans concerning enrollee satisfaction and plan disenrollment. Other measures concerning plan quality are currently under discussion. Data similar to that provided by the OPM are not currently available for Medicare beneficiaries.

The Medicare program could also contemplate establishing more direct control over the marketing practices of plans. Many state Medicaid programs either prohibit direct marketing, or approve marketing materials in advance. This approach is also similar to the trends in the private sector. Employers are actively creating new measures of plan quality and satisfaction which are provided to their employees during open enrollment. With employers organizing the market and collecting relevant data for benchmarking plans, employees receive information on health plans using relatively standardized measures to compare against plan cost. The same activist approach could be used by the Medicare program. Risk selection would be reduced if Medicare assumed a sponsorship role similar to that employed by employers and Medicaid.

A second key implementation issue concerns risk adjustment. Medicare's current approach to risk adjustment, the average adjusted per capita cost (AAPCC) approach accounts for 1 percent of the variation in Medicare spending. Medicare loses money if plans can anticipate the "expected" component of health care spending and enroll patients with low expected costs (Newhouse, et al.1997). Though several improvements in the

AAPCC have been examined, it remains unknown whether any will be adequate to generate savings for the Medicare program.⁸

Finally, even with these changes in place, managed care may not generate recurring savings due to the link between HCFA's approach for paying plans and the fee-for-service market. Thus, if managed care creates recurring savings relative to fee-for-service plans, these savings are either retained by the plans themselves or are passed on to beneficiaries through additional benefits. To generate recurring savings, Medicare must delink capitated payments to health plans from the fee-for-service sector. Several approaches are available, ranging from the use of managed care data to establish rates to rates based on some form of competitive bidding.

IV. Implications of Medicare Reform for the Private Sector

Changes in Medicare policy will also impact the private sector and Medicaid. A full discussion concerning future Medicare options should consider these interactions. For instance, proposals to enhance the Medicare benefit package would also increase spending under the Medicaid program as well as from beneficiaries. Enhancing Medicare benefits would increase the SMI premium. As beneficiaries finance approximately 25 percent of SMI outlays, their monthly premiums would rise. Moreover, both the states and federal government pay these premiums for low-income beneficiaries (generally those under 120 percent of poverty) as well as their cost sharing under the HI program (generally for qualified beneficiaries under 100 percent of poverty). A more

generous Medicare package creating higher expenditures would increase premiums, co-payments and deductibles and therefore spending under Medicaid.

The baseline scenario presented above assumes that Medicare spending per beneficiary would rise at approximately 5 percent, the same rate expected in the private sector. Historically, the growth in Medicare spending per beneficiary has tracked closely the growth in private health insurance premiums (Levit, et al. 1998). At issue is the impact that even slower Medicare growth per beneficiary would have on access to and the quality of care. Some observers believe that even with the recent slowdown in health care spending, health care expenditures could still decrease without harming the quality of care. The belief that excess capacity remains in the delivery system, coupled with billions of dollars in inappropriate and unnecessary care, fuel this view. Alternatively, rather than reducing costs, or care to Medicare beneficiaries, providers could attempt to collect more revenue from those with private health insurance. In this case, Medicare spending would fall, though total health care spending could remain unchanged.

The policy options presented in Table 5 suggest that the additional costs of expanding Medicare benefits could be largely offset by slowly increasing the age of Medicare eligibility. Increasing the age of eligibility for Medicare would track policy changes already adopted by social security (which slowly increases eligibility age to 67). Assuming changes in Medicare eligibility conform with social security, Medicare spending would fall by \$10.2 Billion between fiscal years 1997 and 2007 alone.⁹ At the same time, however, increasing eligibility will also increase the number of uninsured. By

2009, Medicare eligibility would be increased to age 66. In this year, an estimated 2.6 million persons turning age 65 would no longer become eligible for Medicare benefits. By 2027 when fully phased-in over 8.3 million Americans aged 65 and 66 would no longer automatically become eligible for Medicare benefits, reducing the expected number of Medicare beneficiaries by 12 percent. At issue is whether these seniors will be able to secure private health insurance coverage. The proportion securing coverage will depend on the incidence of employment based benefits, retirement benefits, and the price and availability of insurance in the individual market. Absent public policies making such coverage available and affordable for those turning 65, the number of uninsured Americans would rise. Though this policy would reduce Medicare spending, it could have a secondary impact on health insurance coverage of seniors, the demand for uncompensated care, and the ability of the delivery system to provide such care.

V. Conclusions

Two critical issues face policymakers examining the future of Medicare. The first concerns the approach for financing the expected growth in Medicare as the baby-boomers retire. The second issue concerns the quality and quantity of health care that will be provided to seniors over time. A key assumption in any current law projections, particularly those extending over this time period, is the ability of the Congress and the President to constrain spending at the rates highlighted in the analysis over time. Maintaining these tight rates of growth will be very difficult. Federal spending and taxing priorities may change, and with it the delicate balance suggested in these analyses.

Despite these caveats, the analysis presented above presents some preliminary illustrative scenarios for framing the longer term financing debate. The results highlight the critically important role the BBA has assumed in changing the expected budgetary impact of Medicare from just a few years ago. Assuming the BBA policies are extended through 2030, the demographic shifts fueling growth in the Medicare program could be accommodated through reductions (both as a share of the federal budget and as a share of GDP) in discretionary spending and net interest payment on the debt. However, this current policy approach dedicates these savings generated from the BBA to the Medicare and social security programs. The central on-going political debate concerns how these budgetary savings will be spent. These proposals include lower taxes, as well as higher spending on existing and new federal programs. If policymakers follow this course, either additional revenues or lower Medicare spending would be required to finance the demographic shifts.

Policymakers also have an important stake in assuring the successful implementation of Medicare policies crafted in the BBA. The rising share of beneficiaries in managed care will require substantial changes in how this market is organized, and how health plans are paid. Our longer term ability to constrain the growth in Medicare spending will be undermined if the government is unable to produce the range of new prospective payment systems and managed care payment reforms required to generate savings in the near term. At the same time, as Medicare spending becomes constrained, substantial attention needs to focus on maintaining and improving the quality of care provided senior citizens. The discussion presented above noted the inadequacy of the set of benefits currently provided

by Medicare relative to the private sector. Moreover, the program also lacks coverage options for major aspects of long-term care services.

Finally, any substantial changes in the structure and scope of Medicare benefits should consider the interaction of these policy changes with the remaining components of the health care sector. In this sense, the long-term Medicare policy debate should not operate in a vacuum. Changes in Medicare policies will affect those with private insurance, private purchasers and potentially the uninsured. The historic link between the annual growth in private sector spending and public sector spending may provide a useful benchmark for evaluating the fairness of alternative Medicare policy proposals.

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Notes

¹ For instance, if revenues are not sufficient to cover program expenses, the Treasury may not make payments from the HI fund to pay providers. In this case, the fund would be depleted.

² One option would move payments for graduate medical education and disproportionate share expenditures from the HI fund to the SMI program. In addition, one could also establish a single premium based on the actuarial value of both HI and SMI benefits (here the premium amount would be set to collect the same dollar amount of premiums currently collected from the SMI program) with receipts deposited into the HI and SMI programs proportionate to their expenditures. These two approaches would keep the HI trust fund solvent in perpetuity. However, the projected changes in total Medicare spending (assuming the new spending moved from HI to SMI were financed solely from general revenues) would remain precisely the same. Though we would “solve” the HI trust fund problem, these policy changes would not address overall Medicare spending.

³ Revenues here include individual, and corporate income, social insurance revenues as well as offsetting receipts (i.e. premiums from Medicare beneficiaries). The latter is generally considered a reduction in outlays rather than a source of revenue. Under current law, revenues are expected to fall from 20.9 percent of GDP in 1997 to 20.3 percent of GDP by 2008.

⁴ This would move the Medicare benefit package from the 10th percentile in the distribution of private plan generosity to the 50th percentile. Plan generosity is measured as the ratio of payments made through the health plan (i.e. plan benefits) to total expenditures. Based on these distributions, I estimate moving Medicare to the median of this distribution would increase Medicare covered expenses by 20 percent.

⁵ Estimates for increasing the age of Medicare eligibility to age 70 are derived from the Congressional Budget Office (1997). I apply these estimates to the lower current policy baseline presented in Table 4.

⁶ At issue is whether such savings are one-time or recurrent.

⁷ This trend suggest that employers have found it more efficient to restrict choice, and negotiate with a single managed care plan rather than reducing payments through multiple plans competing for employees. In short, savings generate from multiple plan choice may be eroded by the lack of an sufficient method

available to purchasers to risk adjust payments to multiple vendors. What is gained by competition appears eroded by plan selection.

⁸Newhouse, et al. (1997) indicates that even the most promising near term approach would explain only 9 percent of spending. Even with this improvement, Medicare may still overpay plans. Instead, Newhouse suggests the use of a mixed, or blended system. Under a blended approach, health plans would receive a mix of capitation and fee-for-service payment.

⁹ Aligning Medicare and social security eligibility would increase Medicare eligibility by 2 months for each year between 2003 and 2026. For instance, by 2009, Medicare eligibility would be increased to age 66.