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THE GROWTH OF HEALTH ENTITLEMENTS AND THE FEDERAL BUDGET

Statement of Marilyn Moon[1]

before the
Subcommittee on Health and Environment
Committee on Commerce
U. S. House of Representatives
March 28, 1995

I appreciate the opportunity to speak to the committee on the issue of health care spending and the federal budget. My testimony today focuses on Medicare and Medicaid, which together represent about 32 percent of mandatory spending and are projected to constitute nearly 40 percent by 2002. Although these two programs are growing rapidly, that is not necessarily a sign of failure; indeed, these programs play a vital role in our health care system and changes should be made recognizing their contributions. My testimony concentrates on four general points:

- These two programs have grown rapidly not because they are out of control, but because they fill important gaps in the need for health coverage and because health care costs have risen rapidly over time.
- And although health care spending by the private sector has slowed substantially in the last two years, claims that it has been much more efficient than Medicare are considerably exaggerated.
- While it is important to make a number of changes in these programs to slow the rate of growth of spending over time, there are few quick fixes if we wish to protect health care coverage for older, disabled and low income Americans.
- Moving from the rhetoric of budget cutting to sensible changes in these programs requires careful attention if spending reductions are to be successful.

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[1]Senior Fellow, The Urban Institute, Washington, D.C. This statement presents the views of the author and does not necessarily represent the views of the Urban Institute, its trustees, or sponsors.

WHY HAVE THESE PROGRAMS GROWN SO FAST?

It has become fashionable to portray the Medicare and Medicaid programs as failing because their rate of growth is so high. But, are Medicare and Medicaid out of control? How should we interpret these high rates of health care spending? Medicare and Medicaid have both grown rapidly over time, but not all of the growth has been undesirable.

First consider **Medicaid**. During the 1980s through the present, Medicaid has served as the insurance program of last resort for many low income Americans. If not for expansions in Medicaid over the last decade, the number of uninsured persons would be much higher as the share of Americans receiving insurance from employers has dropped. For example, between 1988 and 1992, Medicaid coverage of persons with incomes below 200 percent of poverty increased from 9 to 12 percent of that group while employer-subsidized insurance coverage declined from 67 percent to 63 percent. Thus, without Medicaid, not only would the share of persons without insurance have gone up leaving them vulnerable to catastrophic financial problems, burdens on local and state governments to treat the uninsured would also have risen substantially over the period.

In addition, long term care expenses and care for low income disabled and elderly persons have also contributed to growth. Many people seem to ignore the fact that spending on these beneficiaries constitutes about three quarters of total Medicaid spending.

And over and above these expansions, much of the growth in federal spending on the Medicaid program in the late 1980s and early 1990s reflected states' concerted efforts to bring more state-only programs under Medicaid's jurisdiction (to qualify for matching payments) and to use special financing schemes to dramatically expand their disproportionate

share programs. These loopholes in Medicaid have now largely been closed, resulting in much lower projected rates of growth for the future. For example, in 1993, Medicaid grew by only 11 percent as compared to over 26 percent in each of the previous two years.

Thus, most of the growth in Medicaid in recent years represents expansions in coverage or state-initiated expansions rather than inefficiencies in the program.

Medicare raises other issues. A number of critics of the Medicare program blame it not only for the high costs of health care for the elderly, but for aggravating health care inflation in general. The rapid growth in the program in its early years--expanding well beyond predicted spending levels--is often cited as an example of why government program cannot be trusted.

But the original goal of the legislation creating Medicare was to offer mainstream medical care to older persons and the early fears for the program were that it would not be accepted by doctors and hospitals. Thus, there was a conscious decision not to undertake cost containment efforts initially. Medicare likely did contribute to some inflation as it expanded demand for additional services, but no efforts to counteract this impact were made. And when cost containment efforts were undertaken in the 1980s, Medicare's track record improved substantially, doing better than the private sector for a number of years. In the last two years, private sector growth rates have declined while Medicare's have remained high. This recent low growth in the private sector as compared to Medicare is now being used as a justification for making major changes, some of which might involve "privatizing" the program. But it is extremely difficult to be sure of comparisons made on such short periods of time.

In addition, there are several reasons to expect the rate of growth of Medicare to be higher than that in the private sector over time. First, it is misleading to compare growth rates when the base levels of spending are so different. That is, beginning in the mid 1980s, Medicare held down the rate of growth of payments to hospitals and doctors substantially as compared to private insurance. In the 1990s, as employers have become more serious about costs of health care, that sector is now slowing--but it has a considerable way to go before it matches payment levels in Medicare. There is simply more ability to cut payments to doctors and hospitals in the private sector because they are substantially higher than what Medicare pays.

In addition, both technology and the aging of the population affects the rate of growth of Medicare expenditures, placing special demands on this program. As more people live into their 80s and 90s, the costs of Medicare rise as a result. Further, improvements in technology which make procedures safer and more effective are likely to be more heavily used by the frail for whom riskier procedures were not advisable in the past. For example, cataract, hip replacement and heart by-pass surgeries are areas where major advances have occurred and all are procedures disproportionately used by the elderly. CT scans, MRIs and other advanced imaging techniques also make care safer and more accessible for the elderly and disabled.

I have suggested a number of reasons why we might expect per capita growth in Medicare to rise faster than that in the private sector. But what do the numbers actually tell us? First, for seven of the last ten years, Medicare's per capita growth record has been below that of the private sector. And Medicare's average looks better than the private sector in nine of those ten years if home health and skilled nursing services are taken out of the rates (since

these are largely long term care services which tend not to be covered as extensively by private insurance). The preliminary numbers for 1994 still look very low for the private sector as compared to Medicare--but we do not know if this reflects a true slowdown in the rate of growth of spending or if it mostly captures the one time savings of shifting from more expensive indemnity programs to managed care. Thus, there is as yet little reason to believe that the private sector's experience is superior to that of Medicare.

CAVEATS ABOUT MAGIC BULLETS

Although Medicare and Medicaid growth rates make them tempting targets for budget reduction efforts, simple solutions may be elusive.

Capping Growth as a "Painless" Approach

One popular, but nonspecific proposal for achieving reductions in the federal deficit is to "cap" the growth of entitlements. In recent years, several bills have been introduced in the Congress that would place overall limits on the rate at which entitlements would be allowed to grow. And proposals to make Medicaid a block-granted program also fall into this category. The appeal is that such proposals sound quite technical, but they do not identify who might be affected by these limits. Further, since they still allow positive growth over time, they do not sound very punitive.

But caps themselves are not a "solution"; once such a commitment is made, there is still the issue of exactly how cuts would be accomplished. Caps do not solve the problem of what or how to cut, they simply mandate that some change occurs. And it is when we begin

to examine specific changes such as those described below that harder choices have to be faced.

When Slowing Growth Can be a Cut

One of the major reasons why there is a great deal of focus on entitlement programs--particularly the health programs--is that their projected rates of growth are higher than for other items in the budget. And it has become popular to argue that changes will be relatively painless because they do not result in "cuts" in nominal dollars. But if changes are made to the programs that reduce the rate of growth below what is needed to meet the legal requirements--that is, to absorb expansions in participation as more people become eligible (because of the aging of the population, for example) and as expected inflation in the provision of health services raise costs of providing the benefits specified by law--it is legitimate to refer to these changes as cuts in the program, even if they do not represent dollar cuts in outlays. If the number of persons eligible for a benefit rises by 10 percent, for example, but the budget for a program is allowed to grow by only 5 percent, payments on behalf of each eligible person would have to fall. Individual participants in a program would properly view that as a "cut."

What about the issue of inflation? This is a more complicated question, in part because it depends upon measuring changes that are difficult to know with certainty. If there is inflation which makes it more expensive to continue to provide the same benefit through time, then reductions in the amount available to meet those higher expenses would reduce what the recipient receives in real terms. Again this is legitimately viewed as a "cut." It may

not be possible to "require" that there be no inflation.

On the other hand, if new efficiencies in providing services can be achieved to provide the same benefits at lower cost than projected in the baseline, it is legitimate to argue that lower growth would not reflect a cut. For example, many of the changes legislated in the Medicare program in recent years to slow its rate of growth have focused on payments to the providers of health care, such as doctors and hospitals. By reducing payments but not changing the program in other ways, it is often claimed that Medicare benefits have not been cut. If this reflects efficiencies in the provision of care or reductions in unnecessarily generous payments, then that would be a reasonable characterization. But as Medicare payments relative to the rest of the health care system fall, however, further change may ultimately not only affect providers, but beneficiaries as well in terms of reduced access or lower quality.

Short Run Vs. Long Run Changes

Finally, part of the debate revolves around the need for reducing spending on the Medicare program to avoid a future crisis in the trust fund financing of the program itself. Reductions in Medicare carry the implicit promise of killing two birds with one stone--reducing the current budget deficit of the federal government and helping the long-run stability of the trust fund. Current projections by the actuaries suggest that the trust fund for Part A of Medicare will be depleted by the year 2001. Although that date may slip in the next trustees' report, Medicare needs to be seriously addressed within the next two or three years.

The problem is that savings that help the federal deficit over the next few years may not always be the best long run strategies. For example, many Americans carefully make savings and other long-run decisions on the basis of what they expect to receive from both Social Security and Medicare. Moreover, once individuals retire, it is difficult to return to the labor force or make other changes to compensate for benefit reductions to existing beneficiaries. It is thus important for these programs to change slowly over time in order to remain valuable sources of protection for retirees. These factors make short run savings efforts less desirable. Only when opportunities arise that are consistent with the long term needs of the program does it make sense to take advantage of them for short run relief as well.

A further mistake of much of the discussion is to treat Social Security and Medicare as fully separate programs. Social Security and Medicare are linked, so that problems in one part of our social insurance system will inevitably affect the other parts. Some supporters view one program as essential and the other expendable. But the large and growing share of the federal budget devoted to entitlement programs for seniors suggests that we cannot expect to view each of these programs separately. Some changes will be easier to accomplish in one venue but not the other. For example, Social Security may be the more amenable to changes that affect beneficiaries directly since benefit amounts can be fine tuned in ways that an in-kind benefit program like Medicare cannot. Small adjustments in the benefit formula could make Social Security more progressive--a simpler approach than many of the income-related changes proposed for Medicare.

Thus, putting off any consideration of Social Security, but subjecting Medicare to

major modifications may not be a desirable strategy. For example, proposals such as rolling back the recent increase in taxation of Social Security benefits surely moves in the wrong direction.

MOVING FROM RHETORIC TO SPECIFIC OPTIONS FOR CHANGE

Although cuts in these programs are not likely to be easy, it is crucial to identify areas where we could slow the growth of these programs, while keeping intact their basic goals.

Medicare

The pending financial crisis in Medicare affects Part A of the program, which is funded by payroll taxes. Part A covers hospital services, skilled nursing care and home health services, and so it is in these areas that reductions will most critically need to be found over time. However, changes for Part A offer only a limited range of options for cuts.

One set of changes might be to reduce payments to health care providers for Medicare. This would mean, for example, cutting payments to hospitals, nursing homes, and/or home health agencies. Since hospital services make up the bulk of Part A spending, many of the cuts would have to take place there. Continuation of cuts such as lowering the annual payment updates for hospitals can result in some further decline in Part A spending over its projected level. Alternatively, some specific areas might be targeted such as payments for indirect medical education.

Hospitals, however, are already objecting strongly to the levels of payment they receive under Medicare, arguing that they often do not even cover the costs of such care. To

the extent that they are able, hospitals will attempt to shift any shortfall in payments onto other payers of care, such as private insurance patients. And if there are major shortfalls that cannot be shifted, hospitals and other health care providers may be forced to close their doors or stop treating Medicare patients. Both of these effects create problems for our health care system. Since the early 1980s, Medicare has relied heavily on this type of savings and some further savings are likely possible. At some point, once the gap between costs and what Medicare will pay widens enough, this option will cease to be a viable source of new savings, however.

Another area where change is possible is in seeking better controls on the use of services such as home health care and outpatient hospital services. Both these areas have grown rapidly and been subject to little scrutiny.

Nonetheless, it is likely that future proposals for cutting Medicare will look to changes that would affect beneficiaries directly. These include a new Part A premium or higher cost sharing for the services received. Medicare has never charged a premium for the Hospital Insurance portion of the program, so this would mean a major change in the philosophy of the program. And the existing deductibles and coinsurance under Part A are already very high--certainly as compared to the private sector. For example, the hospital deductible is $716 for the first day of a spell of illness (of which there can be several in a given year).

Some of the proposals for a higher hospital deductible or a new premium would make them income-related. Those with higher incomes would pay more. While this would be fairer than a flat increase and would make higher premiums or deductibles possible since lower income beneficiaries would not have to bear the full burden, this would require either

setting up a whole new administrative structure or using the income tax for processing payments. (A fairer way to raise revenues progressively under Part A would be to expand taxation of Social Security and continue applying it to the Part A trust fund as is now being done with the 1993 Social Security taxation provisions. This effectively creates an income-related premium in Part A without adding a whole new benefit structure.)

Finally, one of the more commonly proposed options for helping the Part A trust fund would be to institute a new coinsurance payment for home health services. The coinsurance on this service was eliminated in 1972 and a number of health care proposals and deficit reduction plans have called for reinstituting the coinsurance, particularly since home health services have been growing rapidly in recent years. Indeed, the Congressional Budget Office has estimated that a 20 percent coinsurance could raise about $20 billion over 5 years. However, this option has particularly undesirable effects on low and moderate income beneficiaries. Because the very old are most likely to use this benefit--and to use it extensively--they would bear the greatest burden from this change. The average user of home health services would face a new coinsurance charge of over $700 per year under this proposal. And because the incomes of these older, frail Medicare beneficiaries tend to be quite low, this would be a particularly regressive change. For example, beneficiaries aged 85 and over would pay coinsurance rates about five times higher than those aged 65 to 69.

Changes on the Part B side (which covers physician services, outpatient care, laboratory services, etc.) are more promising. There the deductible of $100 per year is low by usual standards of comparison with the private sector. And some have suggested raising the Part B premium, which currently stands at $46.10 per month. This might be either an

across the board increase or an income-related one.

The full burden of cost-sharing for the elderly and disabled under Medicare is already quite high, however. Out-of-pocket spending by the elderly for all acute care services will average about $1,382 in 1994. To that should be added the amount that individuals must pay in premiums for Medicare and supplemental insurance--another $1,137. For moderate income families, this is already a substantial burden well in excess of what younger families pay. Any further added burdens ought to be viewed in that context.

Changes to improve the structure of Medicare's cost sharing could be undertaken in such a way as to raise the average burdens somewhat, while protecting the most vulnerable. For example, a lower Part A deductible and coinsurance structure would benefit the oldest old more who are least likely to be able to pay. The Part B deductible could be raised to offset this change and since its burden is more evenly distributed, it would result in a fairer targeting of cost sharing. If raised enough, net savings could be achieved. And some expansion of the Part B premium, likely with an income-related component could also help defray some of the costs of the program.

The limitations of reducing Medicare's growth over time through lower provider payments or higher patient cost sharing lead many to consider a more aggressive strategy for putting Medicare beneficiaries into managed care. This change offers some promise for the future, but we should be wary of moving too rapidly in this direction.

Medicare's experience suggests protections for consumers and careful oversight will be needed to avoid major problems and scandals that could taint reform. HMOs have found it difficult to bring the elderly and disabled into their programs. These patients do not always

behave like younger HMO patients and hence HMOs have sometimes found it more difficult to hold down the costs of care. Policies such as limiting access to specialists may not work well with a population with multiple health care problems, for example. As a result, they have not always been able to cover patients adequately with the payments that Medicare makes on behalf of beneficiaries. There have been some notable crises with HMOs suddenly dropping Medicare enrollees because of such financial difficulties.

And those HMOs that have attracted seniors have sometimes done so selectively, seeking beneficiaries whose average costs will be lower than Medicare's per capita payment not because of better management and oversight of care but because of selecting low-risk patients. Once patients become very ill, some HMOs encourage them to disenroll. The easiest ways for an HMO to limit costs of Medicare enrollees is still to carefully choose those who enroll. And this adverse selection results in a perverse system where Medicare pays too much to HMOs.

But this is not an easy flaw to fix, since most analysts recognize that there is great difficulty in determining a reasonable payment to make to HMOs for each enrollee--a critical factor in assuring that competition among plans occurs fairly. Evidence to date suggests that the voluntary system in Medicare has <u>not</u> reduced Medicare costs. It would be a mistake to move prematurely into this area for Medicare without first resolving a number of these issues.

If this is to be the strategy for Medicare for the future, we should proceed slowly to assure that the system offers protections for beneficiaries, providers, and the government alike. Medicare is too large and the benefits too important to its enrollees to engage in crass experimentation. This suggests that while there may be savings over time from managed

care, it is best to provide for a reasonable transition.

Medicaid

Changes in the Medicaid program ought to also proceed with caution. As the safety net for insurance that protects both vulnerable populations and state and local governments from expenses they would otherwise face, this program is an essential part of our health care system and the only safety net we have. Even though it is expensive, Medicaid does not cover even all of the poor, and its payments to providers are notoriously low. It is not a program for which cuts are easily identified. Nonetheless, Medicaid is particularly at risk, however, because its constituency is less popular than that for Medicare.

Two of the major areas for cutting the program have focused on establishing caps in payments to the states or on expanding managed care. In fact, the claim is often made that states could save enough from managed care to function within very stringent growth rates. Some states are enthusiastically embracing managed care as a means for holding down the costs of existing populations and of expanding coverage to others. Indeed, a growing share of Medicaid beneficiaries are already in managed care arrangements. If these programs move additional Medicaid beneficiaries into good systems of managed care that replace inappropriate use of hospital emergency rooms with early intervention by primary care physicians and other similar changes, then everyone may be better off. This is particularly the case with populations that have lacked reliable providers.

But there are several caveats. We do not know how well these newly emerging managed care programs will do over time: will they be able to serve their clients at the very

low premium levels being offered? This is an experiment and one for which the results are not fully digested. For example, enormous changes will occur in the delivery of care, with fewer resources going to public hospitals that have traditionally served this population and flowing instead into new managed care entities. In many cases, the equation also depends upon moving non-Medicaid uninsured persons into similar arrangements to reduce the burdens of uncompensated care on various providers. Without this concurrent expansion, some of the lower payment levels for existing Medicaid recipients may not be sustainable. In those cases, Medicaid is not seeking savings, but rather a re-arrangement of dollars.

Moreover, many of these exercises that may save Medicaid money concentrate on the under-65, nondisabled population. Moms and kids represent a large number of the participants in Medicaid, but only a small share of the costs. And already, many states have already made such changes, so that some of the savings have already been absorbed. What will happen when we try to move the disabled and elderly into managed care plans, many of which have never treated such populations? This is where the money is and where additional problems and complications are likely to crop up.

Caps on Medicaid in the 5 percent range will likely not be able to achieve their targets without some reductions in services even if states move into more managed care. If states are given greater flexibility, there will likely be reductions in populations served or in services provided.

But even if the decision is made to move in that direction, a substantial problem will arise in deciding how to treat the states. In the case of a cap, for example, one option might be to allow each state no more than 103 or 105 percent of current federal dollars received.

States vary enormously in their programs, however, so that a cap that might be reasonable for a state that is already generous and considering cutting back its program (New York, for example) would be in a much better position to absorb the limit than a state with a less generous program that would like to expand.

The current formula for establishing federal matching rates is acknowledged by many to be in need of substantial change. The level of current federal spending is also affected by states' current abilities and willingness to fund the program. This has led to some states with many needy individuals having very small programs relative to others. How would new formulas or limits deal with these challenges? If we shift from a matching formula to outright block grants, will it still seem fair to have payments to Connecticut be much higher per eligible persons than in Mississippi or Georgia, for example? This is likely to be a very tough issue and one likely to exacerbate rather than improve the inequities in access to a health care safety net across the United States.

CONCLUSIONS

There are no easy solutions for reducing federal spending on health entitlements. Such programs play an essential and valuable role in protecting millions of Americans.1 But if cuts are to be made, there are certainly more and less desirable ways to do so.

First, the long run problems of Medicare suggest that changes will need to be made in this program over time. Some changes would be consistent with short run budget savings, but others ought to be phased in very slowly. Reordering the cost sharing in Medicare, raising Part B premiums in an income-related manner, and some further limits on provider

payments can achieve short-run savings. More work on identifying unnecessary spending on home health services and outpatient hospital care should certainly be undertaken. Over the longer run, it is reasonable to consider further moves into managed care, but a lot of work is needed before moving aggressively in that direction.

Medicaid is more problematic since it serves as a critical safety net for the poorest of our citizens. Some increased flexibility to states might be offered in exchange for lower federal payments, although such reductions or limits on growth should not be applied across the board; a fairer system for establishing payment level changes is needed. In addition, further efforts to reduce misuse of disproportionate share payments could save some federal revenues without putting more vulnerable persons at risk. Managed care is promising as well, but the savings there are likely to be much more modest than many now assume.

Whatever changes are made, it is essential to be honest with Americans when making such cuts: there are few easy or painless ways to do so.

HEALTH CARE SPENDING AND THE FEDERAL BUDGET

Statement by Marilyn Moon[1]
before the
Committee on the Budget
United States Senate
February 1, 1995

I appreciate the opportunity to speak to the committee on the issue of health care spending and the federal budget. Identifying reasonable options for changes in entitlements in general and engaging in a measured and careful discussion of the pros and cons of such options pose formidable tasks. Both those who argue for no change under any conditions and those who would dramatically cut popular and successful programs do a disservice to the goal of finding workable solutions to the future challenges that entitlements will surely face.

My testimony today focuses on the two major health programs in the federal budget--Medicare and Medicaid. These two programs now represent about 32 percent of mandatory spending and are projected to constitute nearly 40 percent by 2002. While it is not possible to address all the issues that ought to be considered in a careful review of these two programs, my testimony concentrates on four general points:

- Rhetoric on the issue of entitlement changes can be misleading, making it important to sort out the basic principles behind some of the common claims made about these programs;
- Although Social Security is not on the table as a current budget issue, its long run inter-relationship with Medicare needs to be kept in mind;
- Medicare and Medicaid tend to be maligned because of their rapid rates of growth, but it is important not to assume that they can be readily brought down to match the rate of growth of federal spending in general; and
- Moving from the rhetoric of budget cutting to sensible changes in these programs requires careful attention if spending reductions are to be successful.

THE PRINCIPLES BEHIND THE RHETORIC

In order to make the business of reducing the federal budget less distasteful, many proponents of major change refer to "reducing the rate of growth of out-of-control

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[1]Senior Fellow, The Urban Institute, Washington, D.C. This statement presents the views of the author and does not necessarily represent the views of the Urban Institute, its trustees or sponsors.

entitlements." This implies mild and relatively painless adjustments, mere technical fine tuning of these programs. Opponents charge that "major cuts would destroy Social Security and health programs." Which set of claims is more accurate? To understand these issues, it is important to examine basic definitions and principles.

Entitlements

In recent years, the term "entitlement" has taken on a pejorative connotation, implying that such programs are easily abused by their recipients. But in actuality this is merely a technical budget term that refers to programs not subject to the annual appropriations process. One is entitled through eligibility and other program rules. The intent of such programs was that they would rise and fall each year in concert with changes in eligibility or to meet other specific requirements (such as the cost of health coverage). There is no inherent reason why entitlements must grow at an unusual pace. It is also likely, however, that few expected such rapid growth in many of the programs at the time of their passage. Thus, it is certainly appropriate to periodically reevaluate whether such preferential treatment is still desired and whether the same level of commitment is appropriate.

If this special budget treatment is deemed to be warranted, the growth of entitlements should be viewed as an intended consequence over time. If not, then like other government programs, the entitlements in question need to be amended.

When a Cut is a Cut

One of the major reasons why there is a great deal of focus on entitlement programs--particularly the health programs--is that their projected rates of growth are higher than for other items in the budget. Baseline projections for the future assume that the programs will grow in a manner sufficient to absorb expansions in participation as more people become eligible (because of the aging of the population, for example) and as cost of living adjustments and expected inflation in the provision of health services raise costs of providing the benefits specified by law.

If changes are made to the programs that reduce the rate of growth below what is needed to meet the legal requirements, it is legitimate to refer to these changes as cuts in the program, even if they do not represent dollar cuts in outlays. If the number of persons eligible for a benefit rises by 10 percent, for example, but the budget for a program remains fixed, payments on behalf of each eligible person would have to fall. Individual participants in a program would properly view that as a "cut."

What about the issue of inflation? This is a more complicated question, in part because it depends upon measuring changes that are difficult to know with certainty. If there is inflation which makes it more expensive to continue to provide the same benefit through

time, then reductions in the amount available to meet those higher expenses would reduce what the recipient receives in real terms. Again this is legitimately viewed as a "cut."

On the other hand, if we find ways to more accurately measure inflation that effectively slows the rate of growth of spending over what was anticipated, then it would be unfairly labeled a cut. That said, however, it is not clear that the ways in which we measure inflation now err only in the direction of overstating inflation. We do not know and so it is important to move slowly in this area. Careful study is needed and it is inappropriate to prematurely conclude that we can "save" a particular amount of money from this exercise. Changes in the Consumer Price Index will have important policy implications, but the exercise should not get entangled in the political process.

Sometimes interpretation of the term "cuts" in programs also depends upon who is being disadvantaged. For example, many of the changes legislated in the Medicare program in recent years to slow its rate of growth have focused on payments to the providers of health care, such as doctors and hospitals. By reducing payments but not changing the program in other ways, it is often claimed that Medicare benefits have not been cut. If this reflects efficiencies in the provision of care or reductions in unnecessarily generous payments, then that would be a reasonable characterization. As Medicare payments relative to the rest of the health care system fall, however, further change may ultimately not only affect providers, but beneficiaries as well in terms of reduced access or lower quality.

Capping Growth as a "Painless" Approach

One popular, but nonspecific proposal for achieving reductions in the federal deficit is to "cap" the growth of entitlements. In recent years several bills have been introduced in the Congress that would place overall limits on the rate at which entitlements would be allowed to grow. And proposals to make Medicaid a block-granted program also fall into this category. The appeal that the proposal sounds quite technical, but does not identify who might be affected. Under these proposals, entitlements would sometimes be linked together with each taking a proportionate hit; in other versions, each program would be bound by its own growth limit. But this is not in itself a "solution"; once such a commitment is made, there is still the issue of exactly how cuts would be accomplished. Caps do not solve the problem of what or how to cut, they simply mandate that some change occurs. And it is when we begin to examine specific changes such as those described below that harder choices have to be faced.

Short Run Vs. Long Run Changes

Finally, part of the debate revolves around the need for cuts in the Medicare and Social Security programs to avoid a future crisis in the trust fund financing of the programs themselves. Reductions in these two programs thus carry the implicit promise of killing two

birds with one stone--reducing the current budget deficit of the federal government and helping the long-run stability of the trust funds that finance these two programs.

The problem is that savings that help the federal deficit over the next few years may not always be the best long run strategies. The unique role that Social Security plays in the lives of Americans is that of a floor of income protection during retirement. Many Americans carefully make savings and other long-run decisions on the basis of what they expect to receive from Social Security and Medicare. Moreover, once individuals retire, it is difficult to return to the labor force or make other changes to compensate for benefit reductions to existing beneficiaries. It is thus important for these programs to change slowly over time in order to remain valuable sources of protection for retirees. These factors make short run savings efforts less desirable. Only when opportunities arise that are consistent with the long term needs of the program does it make sense to take advantage of them for short run relief as well.

THE SPECIAL CHALLENGES OF MEDICARE AND SOCIAL SECURITY

Both Social Security and Medicare will face unprecedented challenges as the Baby Boom generation approaches retirement age. And, for Medicare, the problems are projected to come upon us soon because of the additional burdens of rapidly rising health care costs. Current projections by the actuaries suggest that the trust fund for Part A of Medicare will be depleted by the year 2001. Although that date may slip in the next trustees' report, Medicare needs to be seriously addressed within the next two or three years. Solvency for Social Security will also become a major issue but well after the turn of the century, meaning that adjustments to the Social Security program can be put off for a longer period. But here too the earlier we begin to tackle the problem, the less pain will likely be inflicted on anyone. Any current proposal that affects Social Security or Medicare needs to be viewed in the context of this looming financing crisis.

A further mistake of much of the discussion is to treat Social Security and Medicare as fully separate programs. Social Security and Medicare are linked, so that problems in one part of our social insurance system will inevitably affect the other parts. Some supporters view one program as essential and the other expendable. But the large and growing share of the federal budget devoted to entitlement programs for seniors suggests that we cannot expect to view each of these programs separately. Some changes will be easier to accomplish in one venue but not the other. For example, Social Security may be the more amenable to changes that affect beneficiaries directly since benefit amounts can be fine tuned in ways that an in-kind benefit program like Medicare cannot. Small adjustments in the benefit formula could make Social Security more progressive--a simpler approach than many of the income-related changes proposed for Medicare.

It is difficult to find ways to subdivide Medicare, which is defined as a given level of insurance coverage. One way to do this, for example, would be to income-relate the premium

or to fully means test eligibility. But both of these changes represent major philosophical shifts in the program and would require a substantial new (and expensive) administrative mechanism to enforce those changes. Moreover, Medicare is already a more progressive benefit than Social Security because its value does not rise with the level of contributions made in the past to the program. High wage contributors still receive the same basic benefit as those who contribute substantially less over their working lives.

Thus, putting off any consideration of Social Security, but subjecting Medicare to major modifications may not be a desirable strategy. Proposals such as rolling back the recent increase in taxation of Social Security benefits surely moves in the wrong direction.

THE HEALTH ENTITLEMENTS

It has become fashionable to portray the Medicare and Medicaid programs as failing because their rate of growth is currently above that of the private sector. Moreover, this suggests that "privatizing" of these programs or at least partially contracting out to the private sector will result in substantial savings to the federal government. Are Medicare and Medicaid out of control? How should we interpret these high rates of health care spending? Medicare and Medicaid have both grown rapidly over time, but not all of the reasons for this growth will be tackled by privatization; indeed, not all of the growth is undesirable.

First consider Medicare. A number of critics of the Medicare program blame it not only for the high costs of health care for the elderly, but for aggravating health care inflation in general. The rapid growth in the program in its early years--expanding well beyond predicted spending levels--is often cited as an example of why government program cannot be trusted.

But the original goal of the legislation creating Medicare was to offer mainstream medical care to older persons and the early fears for the program were that it would not be accepted by doctors and hospitals. Thus, there was a conscious decision not to undertake cost containment efforts initially. Medicare likely did contribute to some inflation as it expanded demand for additional services, but no efforts to counteract this impact were made. And when cost containment efforts were undertaken in the 1980s, Medicare's track record improved substantially, doing better than the private sector for a number of years. In the last two years, private sector growth rates have declined while Medicare's have remained high. This recent low growth in the private sector as compared to Medicare is now being used as a justification for privatizing the program. But it is extremely difficult to be sure of comparisons made on such short periods of time.

In addition, there are several reasons to expect the rate of growth of Medicare to be higher than that in the private sector over time. First, it is difficult to compare growth rates without knowing the base in both sectors. Beginning in the mid 1980s, Medicare held down the rate of growth of payments to hospitals and doctors substantially as compared to private

insurance. In the 1990s, as employers have become more serious about costs of health care, that sector is now slowing--but it has a considerable way to go before it matches payment levels in Medicare.

In addition, both technology and the aging of the population will affect the rate of growth of Medicare expenditures, placing special demands on this program. As more people live into their 80s and 90s, the costs of Medicare rise as a result. Further, improvements in technology which make procedures safer and more effective are likely to be more heavily used by the frail for whom riskier procedures were not advisable in the past. For example, cataract, hip replacement and heart by-pass surgeries are areas where major advances have occurred and all are procedures disproportionately used by the elderly. CT scans, MRIs and other advanced imaging techniques also make care safer and more accessible for the elderly and disabled.

In the case of the Medicaid program, a number of different factors apply. During the 1980s through the present, Medicaid has served as the insurance program of last resort for many low income Americans. If not for expansions in Medicaid over the last decade, the number of uninsured persons would be much higher as the share of Americans receiving insurance from employers has dropped. And without Medicaid, burdens on local and state governments to treat the uninsured would rise substantially. In addition, long term care expenses and care for low income disabled and elderly persons have also contributed to growth.

But even with these expansions, much of the growth in federal spending on the Medicaid program in the late 1980s and early 1990s reflected states' concerted efforts to bring more state-only programs under Medicaid's jurisdiction (to qualify for matching payments) and to use special financing schemes to dramatically expand their disproportionate share programs. These loopholes in Medicaid have now largely been closed, resulting in much lower projected rates of growth.

All of this suggests that while there are likely opportunities for scaling back these programs, simple solutions may be elusive.

MOVING FROM RHETORIC TO SPECIFIC OPTIONS FOR CHANGE

Since this hearing is focused on the short run budget changes that might be made in entitlement programs and since Social Security is not on the table for discussion, I focus below only on some of the options for changing Medicare and Medicaid.

Medicare

The pending financial crisis in Medicare affects Part A of the program, which is funded by payroll taxes. Part A covers hospital services, skilled nursing care and home

health services, and so it is in these areas that reductions will most critically need to be found over time. However, changes for Part A offer only a limited range of options for cuts.

One set of changes might be to reduce payments to health care providers for Medicare. This would mean, for example, cutting payments to hospitals, nursing homes, and/or home health agencies. Since hospital services make up the bulk of Part A spending, many of the cuts would have to take place there. Hospitals, however, are already objecting strongly to the levels of payment they receive under Medicare, arguing that they often do not even cover the costs of such care. To the extent that they are able, hospitals will attempt to shift any shortfall in payments onto other payers of care, such as private insurance patients. And if there are major shortfalls that cannot be shifted, hospitals and other health care providers may be forced to close their doors or stop treating Medicare patients. Both of these effects create problems for our health care system. Since the early 1980s, Medicare has relied heavily on this type of savings and some further savings are likely possible. At some point, once the gap between costs and what Medicare will pay widens enough, this option will cease to be a viable source of new savings, however.

A number of proposals for cutting Medicare thus look elsewhere to changes that would affect beneficiaries directly. These include a new Part A premium or higher cost sharing for the services received. Medicare has never charged a premium for the Hospital Insurance portion of the program, so this would mean a major change in the philosophy of the program. And the existing deductibles and coinsurance under Part A are already very high--certainly as compared to the private sector. For example, the hospital deductible is $716 for the first day of a spell of illness (of which there can be several in a given year).

Some of the proposals for a higher hospital deductible or a new premium would make them income-related. Those with higher incomes would pay more. While this would be fairer than a flat increase and would make higher premiums or deductibles possible since lower income beneficiaries would not have to bear the full burden, this would require either setting up a whole new administrative structure or using the IRS. As described above, a fairer way to raise revenues progressively under Part A would be to expand taxation of Social Security and continue applying it to the Part A trust fund (as is now being done with the 1993 Social Security taxation provisions).

Finally, one of the more likely options for helping the Part A trust fund would be to institute a new coinsurance payment for home health services. The coinsurance on this service was eliminated in 1972 and a number of health care proposals and deficit reduction plans have called for reinstituting the coinsurance. Indeed, the Congressional Budget Office has estimated that a 20 percent coinsurance could raise about $20 billion over 5 years. However, this option has particularly undesirable effects on low and moderate income beneficiaries. Because the very old are most likely to use this benefit--and to use it extensively--they would bear the greatest burden from this change. The average user of home health services would face a new coinsurance charge of over $700 per year under this proposal. And because the incomes of these older, frail Medicare beneficiaries tend to be

quite low, this would be a particularly regressive change. For example, beneficiaries aged 85 and over would pay coinsurance rates about five times higher than those aged 65 to 69.

Changes on the Part B side (which covers physician services, outpatient care, laboratory services, etc.) are more promising. There the deductible of $100 per year is low by usual standards of comparison with the private sector. And some have suggested raising the Part B premium, which currently stands at $46.10 per month. This might be either an across the board increase or an income-related one.

The full burden of cost-sharing for the elderly and disabled under Medicare is already quite high, however. Out-of-pocket spending by the elderly for all acute care services will average about $1,382 in 1994. To that should be added the amount that individuals must pay in premiums for Medicare and supplemental insurance--another $1,137. For moderate income families, this is already a substantial burden well in excess of what younger families pay. Any further added burdens ought to be viewed in that context.

Changes to improve the structure of Medicare's cost sharing could be undertaken in such a way as to raise the average burdens somewhat, while protecting the most vulnerable. For example, a lower Part A deductible and coinsurance structure would benefit the oldest old more who are least likely to be able to pay. The Part B deductible could be raised to offset this change and since its burden is more evenly distributed, it would result in a fairer targeting of cost sharing. If raised enough, net savings could be achieved. And some expansion of the Part B premium, likely with an income-related component could also help defray some of the costs of the program.

The limitations of reducing Medicare's growth over time through lower provider payments or higher patient cost sharing lead many to consider a more aggressive strategy for putting Medicare beneficiaries into managed care. This change offers some promise for the future, but we should be wary of moving too rapidly in this direction.

Medicare's experience suggests protections for consumers and careful oversight will be needed to avoid major problems and scandals that could taint reform. HMOs have found it difficult to bring the elderly and disabled into their programs. These patients do not always behave like younger HMO patients and hence HMOs have sometimes found it more difficult to hold down the costs of care. As a result, they have not always been able to cover patients adequately with the payments that Medicare makes on behalf of beneficiaries. There have been some notable crises with HMOs suddenly dropping Medicare enrollees because of such financial difficulties. And those that have attracted seniors have sometimes done so selectively, seeking beneficiaries whose average costs will be lower than Medicare's per capita payment not because of better management and oversight of care but because of selecting low-risk patients. Once patients become very ill, some HMOs encourage them to disenroll.

Consequently, such activities cast doubt on whether these arrangement truly save costs for the Medicare program at present. Moreover, the program has had difficulty in determining a reasonable payment to make to HMOs for each enrollee--a critical factor in assuring that competition among plans occurs fairly. Evidence to date suggests that the voluntary system in Medicare has not reduced Medicare costs. It would be a mistake to move prematurely into this area for Medicare without first resolving some of these issues.

Medicaid

Changes in the Medicaid program ought to also proceed with caution. As the safety net for insurance that protects both vulnerable populations and state and local governments from expenses they would otherwise face, this program is an essential part of our health care system and the only safety net we have. Even though it is expensive, Medicaid does not cover even all of the poor, and its payments to providers are notoriously low. It is not a program for which cuts are easily identified. Nonetheless, Medicaid is particularly at risk, however, because its constituency is less popular than that for Medicare.

Two of the major areas for cutting the program have focused on establishing caps in payments to the states or on expanding managed care. Some states are enthusiastically embracing managed care as a means for holding down the costs of existing populations and of expanding coverage to others. Indeed, a growing share of Medicaid beneficiaries are already in managed care arrangements. If these programs move additional Medicaid beneficiaries into good systems of managed care that replace inappropriate use of hospital emergency rooms with early intervention by primary care physicians and other similar changes, then everyone may be better off.

But there are several caveats. We do not know how well these newly emerging managed care programs will do over time: will they be able to serve their clients at the very low premium levels being offered? This is an experiment and one for which the results are not fully digested. For example, enormous changes will occur in the delivery of care, with fewer resources going to public hospitals that have traditionally served this population and flowing instead into new managed care entities. In many cases, the equation also depends upon moving non-Medicaid uninsured persons into similar arrangements to reduce the burdens of uncompensated care on various providers. Without this concurrent expansion, some of the lower payment levels for existing Medicaid recipients may not be sustainable. In those cases, Medicaid is not seeking savings, but rather a re-arrangement of dollars.

Moreover, many of these exercises that may save Medicaid money concentrate on the under-65, nondisabled population. Moms and kids represent a large number of the participants in Medicaid, but only a small share of the costs. What will happen when we try to move the disabled and elderly into managed care plans, many of which have never treated such populations? This is where the money is and where additional problems and complications are likely to crop up.

Caps on Medicaid will likely not be able to achieve their targets without some reductions in services even if states move into more managed care. If states are given greater flexibility, there will likely be reductions in populations served or in services provided.

But even if the decision is made to move in that direction, a substantial problem will arise in deciding how to treat the states. In the case of a cap, for example, one option might be to allow each state no more than 103 or 105 percent of current federal dollars received. States vary enormously in their programs, however, so that a cap that might be reasonable for a state that is already generous and considering cutting back its program (New York, for example) would be in a much better position to absorb the limit than a state with a less generous program that would like to expand. The current formula for establishing federal matching rates is acknowledged by many to be in need of substantial change. The level of current federal spending is also affected by states' current abilities and willingness to fund the program. This has led to some states with many needy individuals having very small programs relative to others. How would new formulas or limits deal with these challenges? This is likely to be a very tough issue and one likely to exacerbate rather than improve the inequities in access to a health care safety net across the United States.

CONCLUSIONS

There are no easy solutions for reducing federal spending on health entitlements. Because such programs play an essential and valuable role in protecting millions of Americans and cuts in these programs would not be my preferred means for achieving a balanced budget over time. But if cuts are to be made, there are certainly more and less desirable ways to do so.

First, the long run problems of Social Security and Medicare suggest that changes will need to be made in these programs over time. Some changes would be consistent with short run budget savings, but others ought to be phased in very slowly. To the extent that reasonable short run changes can be identified, there is no valid reason for protecting Social Security but not Medicare since the impacts on beneficiaries will often be similar.

In the health area, some changes are possible. Reordering the cost sharing in Medicare, raising Part B premiums in an income-related manner, and some further limits on provider payments can achieve short-run savings. Over the longer run, it is reasonable to consider further moves into managed care, but a lot of work is needed before moving aggressively in that direction. Medicaid is more problematic, but further efforts to reduce misuse of disproportionate share payments could save some federal revenues without putting more vulnerable persons at risk.

Whatever changes are made, it is essential to be honest with Americans when making such cuts: there are few easy or painless ways to do so.

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Lessons From Medicare

Marilyn Moon, PhD,[1]

The Medicare program poses many challenges for health care reform. And many of these create difficult tradeoffs for the Clinton Administration and the Congress in the debate to shape a viable health care policy for the nation. This is particularly difficult since Americans hold conflicting views about the role of government and the success of the Medicare program. Despite Medicare's popularity, policy makers and the public tend to be suspicious of government and its ability to tackle health care reform. Consequently, the health care reform proposal presented to the Congress by the Clinton Administration in the fall of 1993 took a very different approach than that of Medicare, and essentially would result in a two-tiered system: Medicare, and "everything else."

In the early stages of forming the Clinton proposal, the Administration was guided by a number of presumptions: that the elderly and disabled wanted to keep Medicare a separate program, that elderly groups could be satisfied with a few key expansions of benefits, and that Medicare was loaded with inefficiencies that make it a reasonable source of "savings" to be used to fund the program. The Administration relied on feedback from groups such as the American Association of Retired Persons; the early signals were that protection of the fee-for-service structure of Medicare, expanded prescription drug coverage, and some new long-term care benefits were the most critical concerns of older persons. Moreover, a key figure in the development of the health care plan, Ira Magaziner, was highly critical of the way in which Medicare has controlled spending, leading him to push for a cost containment structure for the rest of the health care system that further isolated Medicare. For a number of reasons, however, these early assumptions have resulted in a proposal that does not comport with the lessons that we should draw from Medicare and that ultimately may not satisfy older Americans.

This article examines a number of the lessons that can be drawn from Medicare and explores how both the Medicare program and the system in general might be further improved. Before turning to these issues, however, it is important to consider how Medicare is treated in the Clinton proposal and the problems that may be created by establishing what would effectively become two separate systems for providing health care in the United States. Although the Clinton proposal will not survive this debate intact, its details are illustrative of many of the approaches under discussion.

Medicare and the Clinton Health Plan

The proposal of the Clinton Administration sought massive changes in the health care system (U.S. Congress, 1993). The plan would achieve universal coverage through an employer-based financing approach supplemented with government subsidies for nonworkers. Employers' required payments would take the form of premium contributions of approximately 80% of the costs of a generous plan. Special subsidies would be offered to employers with fewer than 75 workers whose average wages are below $24,000 per year, in order to reduce the disproportionate burdens that group would bear. There would also be an upper bound guarantee for all employers that required payments would not exceed 7.9% of payroll. The plan would also offer subsidies to low-income individuals and families who do not receive coverage through the work force. Reliance on an employer mandate maintains a major role for the private sector, and thus limits the amount of tax dollars necessary to obtain universal insurance coverage. It would effectively eliminate Medicaid as a separate program, folding that population into the alliance system.

Most people would receive their insurance coverage by choosing among several qualifying plans offered by a regional alliance. The alliances operate as clearinghouses, overseeing the operation of the plans and enrollment by individuals and families. Employers would make their required contributions to these alliances, but the choice of specific plan would be up to each family. Similarly, individuals now in Medicaid or otherwise subsidized by the federal government would also enroll in health plans via these alliances.

Another major piece of this proposal, the cost containment portion, would rely upon competition among these health plans to hold down costs (referred to as "managed competition"). Plans would be encouraged to operate in a managed care environment (also expected to reduce the costs of care), but fee-for-service accountable health plans would

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Critical Issues in U.S. Health Reform

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The Role of Medicare in Reform

Marilyn Moon

Medicare is a critical piece of our current health care system. In fact, many reform proposals treat Medicare's basic structure as "untouchable," suggesting only modest changes in the program while significantly altering many other aspects of the health care system. Nevertheless, it would be a mistake to view Medicare as irrelevant to the reform process. First, Medicare's experience offers important perspectives—both positive and negative—for reform. Moreover, changes elsewhere in the system will have an effect on the Medicare program; it is not possible to enact reforms that dramatically change the delivery of care without also affecting Medicare, even if no formal provisions of the program are altered. And the one area in which most proposals would affect Medicare—cuts in payments to providers to help fund other expansions—may place the program at risk.

Medicare also has a number of problems, acknowledged by even its most fervent supporters, that might be improved as part of overall health care reform. At a minimum, changes in Medicare ought to be considered to ensure its coordination with the rest of the new system. Furthermore, many observers predict that if there is major legislation in the next year or so, we are unlikely to revisit this issue again for some time. If that is the case, major reforms that could improve Medicare deserve attention.

The Importance of Medicare

Medicare serves those most in need of medical care—the elderly and disabled. It remains one of the most popular federal programs, having changed little in its first 27 years. But this important program also carries a substantial price tag; spending in 1993 totaled about $144 billion for 34 million enrollees. Expenditures of over $4,000 per enrollee accounted for over 18 percent of total spending on health services.[1] As a large and visi-

ble part of our health care system, Medicare's importance should not be underestimated.

Medicare as a Provider of Mainstream Services

At its passage in 1965, the overriding goal of the Medicare program was to assure access to mainstream care for persons over the age of 65. The elderly were underserved by the health care system, largely because many older persons could not afford care. Insurance coverage as a part of retirement benefits was often the exception, not the rule.[2] Moreover, private insurance companies had shown a reluctance to offer coverage to older persons, even when they could afford it. Even in the 1960s, risk selection was a barrier to achieving broad coverage. In the early part of the decade, the country began to separate into two camps, the health care haves and have-nots, as defined by access to insurance protection. The elderly comprised a disproportionate share of the have-nots.

Strong opposition to a public program by groups like the American Medical Association meant that most of the attention was devoted to allaying fears about government control. Consequently, the rules established to govern Medicare did little to disrupt or change the way that health care was practiced or financed in the United States. Claims processing resembled the method used in the private sector, and Medicare statutes specifically assured free choice of provider and no interference in the routine practice of medicine. Payment rates also were similar to those followed by the private sector, both in the mechanics and the level of remuneration. Physician and other provider groups would at least not be put at a financial disadvantage if they participated in the new program.

By most accounts, Medicare achieved the goal of improved access to health care for the nation's elderly and disabled. Boycotts, which had been threatened by groups of health care providers, did not take place. By 1970, Medicare had enrolled nearly all of the elderly, and after 1972 it added a substantial number of disabled people.[3] However, the relative success of the program contributed to a rapid growth in federal costs, thus ushering in the second phase of Medicare—a concern for cost containment. Attention turned to restraining the growth in program spending.

While critics are quick to point out Medicare's rapid growth, which has outpaced all cost projections, they ignore the fact that this was not the most important element of Medicare in the early years. When attention did turn to costs in the late 1970s, Medicare continued to grow faster than the rest of the system, perhaps in part because of the program's unique aspects, which will be discussed below. But in the late 1980s, Medicare's rate of spending growth declined faster than the rate of health care spending

for the entire population, as indicated in Figure 9.1.[4] Thus, even in the area of cost containment, Medicare deserves more credit than its critics often allow.

Positive Lessons from Medicare

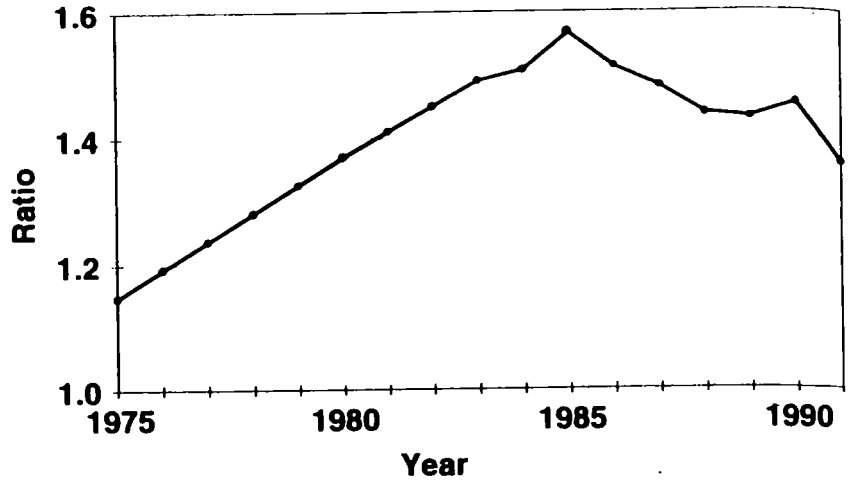
Over the last 27 years, Medicare has had a considerable record of success that offers some positive lessons for those who would reform the health care system. While the Clinton Administration's proposal consciously takes an approach quite different from Medicare, many others have incorporated pieces of the program into their proposals, particularly the benefit package and some of the cost-containment mechanisms.

One of the most important lessons of Medicare is that government programs can be viewed favorably by the population they serve and by the public-at-large. In general, Medicare is well liked by its beneficiaries and has significantly enhanced their economic well-being and access to mainstream health care. Medicare is consistently rated as one of the most valued government programs, its benefits are clear and highly visible, and it is supported by a dedicated revenue source that constitutes a popular means of financing. Despite the Clinton Administration's skepticism about a publicly funded "single-payer" system, Medicare demonstrates that such a program can operate successfully in the United States.

Medicare's innovations include new payment mechanisms for providers, and while hospital administrators and physicians have grumbled about the changes, they have generally adjusted quickly to these new incentives. As a result, Medicare has been relatively successful in holding down costs, particularly those of hospital services in the late 1980s. The prospective payment system for hospitals has been widely accepted as an improvement over the old cost-based method. It changed the basic incentives which guided hospitals and made them more conscious of ways to improve efficiency. In addition, the new Medicare fee schedule for physicians, while controversial, is likely to become a standard for physician payment.[5]

These two reform efforts, particularly hospital reform, reflected major changes in the way payments were made and required new accounting systems and behavioral responses to the new incentive structures. While not all the responses were positive, the delivery of health care did change rapidly. For example, the average number of days in a hospital stay dropped dramatically when hospitals were paid on a per case rather than per diem basis.[6] While a study of the response to these hospital reforms uncovered some problems, particularly regarding patient stability upon discharge, it concluded that quality was not seriously compromised.[7]

Figure 9.1: Ratio of Per Capita Medicare Benefits to Per Capita Spending on Health



Source: U.S. Congress, Committee on Ways and Means, 1993 Green Book: Overview of Entitlement Programs (Washington D.C., USGPO, July 7, 1993).

Overall, these transitions suggest that the health care system can respond to change without experiencing significant disruption of services or quality of care.

Finally, one of the major Medicare successes is its low administrative overhead, which accounts for less than 3 percent of spending compared to about 10 percent for private health insurance for large groups and as much as 40 percent in the small-group market.[8] Proponents of a completely public system of health care use these administrative cost differences to calculate what could be saved by moving away from private insurance. While these comparisons can be overblown (and admittedly, Medicare is sometimes faulted for too little beneficiary service), Medicare administration is often cited as a positive model for the rest of our health care system.

Unique Issues Confronting Medicare

Medicare differs from other parts of our health care system in a number of aspects which pose unique challenges for reform and may argue for some special considerations, especially regarding cost containment. First, as a publicly funded program, Medicare is vulnerable to the pressures of budget reduction efforts. And although public financing may increase support for tighter restraints on Medicare than on the rest of the health care system, there are major factors that boost the costs of the program—the demands on services near the end of life, the aging population, advancing technology, and the consequences of omitting long-term care services from Medicare. These constraints need to be considered when assessing how Medicare should be treated relative to the rest of the health care system, particularly with regard to expected rates of growth.

The Special Pressures on a Public Program

Relative to total health care costs, Medicare performed rather well in the 1980s, but it is still viewed as a runaway line item in the federal budget. Since Medicare is funded with tax dollars in an era of anti-tax sentiment, it gets more scrutiny than health expenditures paid for by individuals or businesses. Moreover, its absolute size and rate of growth distinguish it from most other domestic programs. In the 1970s Medicare accounted for only 3.5 percent of the federal budget; by 1990, it consumed 8.6 percent. Even with the cuts instituted in 1993, Medicare's budget share in 1995 will likely total more than 11 percent.[9] In the view of many policymakers, Medicare may be crowding out expenditures on other domestic programs and/or standing in the way of curbing the overall growth in federal outlays. Critics often argue that Americans will only accept a certain level of public spending, so if Medicare grows rapidly, it hurts other programs even if it has its own revenue source. This alone makes it a potential mark for budget reduction.

The most recent example of Medicare as a target is the Penny-Kasich budget amendment. Offered in the fall of 1993, it aimed to further slash Medicare spending by $37 billion for the purpose of reducing the deficit.[10] This cut would have come over and above the $56 billion, five-year savings included in the Omnibus Budget Reconciliation Act (OBRA) of 1993. The Penny-Kasich amendment failed by just a few votes in the House of Representatives; similar measures will likely surface in the 1995 budget cycle regardless of the status of health care reform.

A second fiscal pressure faced by Medicare is linked with the status of the Hospital Insurance (HI) trust fund. Current law provides a fixed source of funding for HI, and these revenues are not growing as fast as the level of spending, thus creating a likely future crisis when the trust funds are exhausted. That day of reckoning has been postponed several times, thanks to cost-cutting efforts and an increase in the wage base subject to taxation. The last formal projection placed the trust fund's expiration at 1999,[11] but that will probably be delayed for a few years by the OBRA 1993

provisions. Thus even strong supporters of the Medicare program face the prospect of further alterations involving either an increase in the payroll tax rate devoted to Medicare or a reexamination of the program itself.

In addition to these budget pressures, Medicare is treated to the same skepticism about government spending that affects Americans' view of all public programs. There is a perception that, because it is a government program, Medicare is by definition bureaucratic and wasteful. In fact, the evidence suggests that while Medicare is not perfect, in some cases its shortcomings may stem more from too little spending on administration rather than too much. For example, complaints about poor services and program complexity may result in part from tight claims-processing budgets. (As mentioned above, Medicare administrative costs are comparatively low.)

Under the reform proposals of the Clinton Administration and others that rely on a private/public system of financing, Medicare would retain its unique position as a highly visible public program, while the rest of the system would essentially be kept "off budget." Medicare is thus more likely to be a target in each fiscal year's budget, over and above proposals designed to restrain health care spending. Ironically, for some of the reasons detailed below, Medicare spending may be more difficult to control than other types of health spending.

The End of Life

Since Medicare covers the population over the age of 65, and since most Americans now live into their 70s and 80s, many who die each year were Medicare beneficiaries. Medical expenses in the last year of life are quite high on average, resulting in high average spending levels for Medicare. Average acute care spending for persons over age 65 is about 3.8 times as great as that for those under age 65, and Medicare expenditures on behalf of the disabled are even higher than those for elderly beneficiaries.[12] Many casual observers suggest that controlling the use of services in the last year of life may be the "magic bullet" needed to control health care spending. But like most "magic bullets" aimed at the health care system, there is more to the story than just excessive spending on hopeless cases. For instance, are we devoting an increasing share of health resources in vain attempts to forestall death, often through use of new technology? Certainly, few numbers sound as compelling as the widely quoted statistic that 28 percent of Medicare spending went to the 5 percent of enrollees living their last year of life.[13] Such statistics are cited by those who believe that a key to controlling health care costs will be to limit spending on the very old.

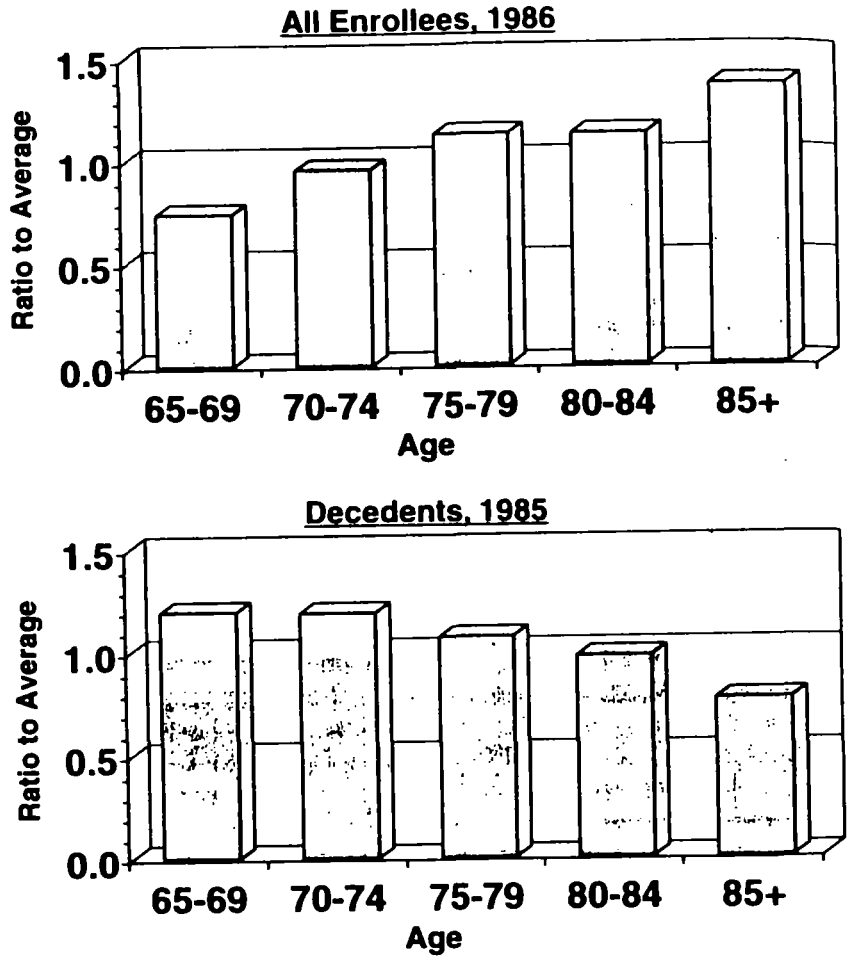
But a careful look at the data suggests that the answer is not nearly so simple. First, if technology is being used extensively in futile cases involving the very old, the share of resources devoted to health care in the last year of life should be rising. The evidence, however, does not support this claim. Anne Scitovsky discovered that high expenditures were not a new phenomenon; in fact, they preceded Medicare's introduction in 1965. More recently, Lubitz, updating an earlier study, found that between 1976 and 1985, a period of enormous cost growth in health care, there was no increase in the share of Medicare resources going to those in the last year of life.[14] The proportion of decedents increased slightly but the proportion of Medicare dollars fell slightly.

Further disaggregation of Medicare data also reinforces this analysis. Looking at Medicare expenditures by age, the familiar pattern of more spending on the very old emerges again (Figure 9.2), thus seeming to support claims about disproportionate spending on the very old. However, the data show exactly the opposite pattern for persons in their last year of life, with considerably more spent on 65 to 69 year olds who died than on decedents over age 85. That is, more is spent on younger Medicare beneficiaries who are more likely to recover—a result consistent with reasonable health care policy. Since life expectancy at age 65 is now about 17 years, spending on the younger old is not necessarily just "cheating death" for a few months, but rather treating patients with many useful years left.[15]

These findings suggest several important points. First, physicians do not always know that death is imminent when making health care spending decisions. And since people often die after being ill or requiring medical treatment, it is only natural to see extraordinary health care spending for those in the last year of life, as well as for those who survive a major illness. More appropriately stated, the issue is whether or not we spend inordinately on those with no chance of survival, and whether such outlays contribute substantially to the boom in health care spending. Here the evidence is much weaker. Compared to the young, there does seem to be a dip in spending on the very old in their last year of life, suggesting that decisions are being made to resist heavy acute care expenditures.

The dilemma of excessive use of medical care by the elderly thus is overstated. Probably the most that can be said is that we should expect expenditures to be high for those who are gravely ill and at risk of death. Certainly, some things could be done to try to reduce these expenditures, but quick and dirty solutions are probably not the answer for Medicare or the rest of the health care system. However, Medicare does face some unique challenges in assessing inappropriate care and in finding ways to manage a disproportionate number of high cost cases.

Figure 9.2: Per Capita Medicare Spending by Age as Compared to Overall per Capita Medicare Spending



Sources: U.S. Department of Health and Human Services, Health Care Financing Administration, Medicare and Medicaid Data Book, 1990, HCFA Pub. 03314 (Washington D.C., USGPO, 1991); and James Lubitz Use and Costs of Medicare Services in the Last Year of Life, 1976 and 1985 (mimio, Baltimore, May 11, 1990).

The Aging Population

It is not just end-of-life spending that leads to higher costs for Medicare than for the rest of the population. The number of Medicare enrollees is growing at a faster rate than the population in general, and most of that growth is occurring among the very old who have higher than average levels of expenditure. As a result, we should expect more rapid growth per capita, as well as on a population basis.

The aging of the population probably adds about 1 percentage point to the growth of Medicare spending each year relative to the rest of the population.[16] This is not a large amount, but it will become more significant as pressures rise to hold down the cost of care. And it means that just to keep Medicare on an even footing with the rest of the health care system, spending growth per capita should be higher for Medicare.

The Role of Technology

One of the significant pressures on health care spending arises from the use of new technology, but these pressures may be disproportionately large for the Medicare population. Technology has given us new tools such as computerized tomography (CT) scans and magnetic resonance imagers (MRIs), and new procedures such as endoscopies and arthroscopies. These new sources of health care spending tend to operate as extra goods and services consumed rather than as replacements for old technologies or procedures. For example, people may now receive x-rays, CT scans *and* MRIs to diagnose a problem where before only x-rays (and perhaps exploratory surgery) were available. And it is now as easy to subject a blood sample to 30 or 40 different tests as it is to one. These new technologies are often less invasive, and consequently less risky, than earlier means of detecting illness. For example, an MRI is often safer than exploratory surgery for many older or disabled patients. Thus it is no surprise that these new tests constitute the fastest rising categories of services under Medicare.[17]

Although increasingly more complex and expensive over time, the use of surgery and other technical procedures also continues to grow. For example, cardiac bypass surgery rates for men over the age of 65 rose from 2.6 per 1,000 in 1980 to 10.4 per 1,000 in 1989.[18] The increasing success rates for procedures such as hip replacement and cataract surgery translates to lower surgical risks and improved outcomes. In such cases, higher rates of use would certainly be appropriate since the value of these procedures to individuals has increased over time. And again, lower risks mean that older or disabled patients are particularly more likely to benefit. It should not be surprising then that cost of care for these groups is rising rapidly.

With such changes pervading the U.S. health care system, technology may have an even greater impact on Medicare spending and rates of service use within the older population. The combination of an aging population and the special benefits of new technology for frail populations underscores the belief that Medicare will have difficulty holding down its rate of growth, both absolutely and relative to the rest of the population.

The Challenges Posed by the Need for Long-Term Care

Although Medicare covers only acute care services, recipients are also likely to need long-term care. Because such services are expensive and public coverage is limited to the welfare-based Medicaid program, available acute care services may be substituted for inadequate long-term care. As the major insurer affected, Medicare likely has higher costs as a result of this misuse. For example, Medicare's home health benefit is intended to provide rehabilitation and other medical services, but it may also serve as a long-term home care benefit. Rapid growth in home health care since eligibility regulations were eased in 1989 may be attributable to its increasing use as a chronic care, as well as an acute care, benefit.[19] Pressures to use skilled nursing facility beds to meet long-term care needs also have helped raise Medicare spending, particularly since 1988. And before hospital reforms shortened lengths of stay, Medicare often paid for extra inpatient days while patients waited for nursing home placement.

Expansion of long-term care coverage merits more careful analysis, and any revision should be well-coordinated with other reforms. While improved long-term care coverage makes sense for meeting the needs of the elderly and disabled and to reduce inappropriate reliance on acute care services, its prohibitive costs probably preclude significant relief in this area. However, if little expansion of long-term care is included in reform, the pressures to misuse Medicare will persist.

The Lack of an Integrated Approach in Reform Options

One of the most troubling aspects of the Clinton Administration's health care reform proposal is its attempt to establish an elaborate new structure for young, nondisabled families and individuals while keeping Medicare a separate program.[20] But the Clinton proposal should not be singled out for criticism; except for the single-payer approach of Senator Wellstone and Congressman McDermott, the other major reform proposals now being debated would also keep Medicare separate while cutting its expenditures. There are two compelling reasons for this: (1) the strong, early signals from interest groups that Medicare beneficiaries did not want their

program to be part of this new "experiment," and (2) the costs of fully integrating Medicare with the rest of the plan.

Nevertheless, the separation is likely to create at least the *perception* of inequity and to generate undesirable complications. Once the reality of the discrepancy in benefits and cost sharing is realized by Medicare beneficiaries, there will likely be an enormous outcry. The Clinton approach to reform also maintains, and perhaps enlarges, a "wedge" between what Medicare and the proposed insurance purchasing alliances for younger families would pay for physician, hospital and other services. This arises from the use of Medicare savings to help fund expansions in the rest of the program. Any modification of these two parts of the Clinton proposal would be enormously expensive, however. Consequently, the costs of full integration into a single health care system might require some changes that Medicare beneficiaries would find undesirable, such as greater contributions toward the cost of expanded care.

Perceived Inequities

Although the Clinton proposal would improve benefits under the Medicare program by adding new prescription drug coverage, beneficiaries are likely to compare their benefit package to that guaranteed to younger families and individuals. What they will soon discover is that while the list of benefits is comparable, required deductibles and protections for catastrophic expenses are more generous in the Clinton proposal. The benefit package for those in the alliances is intentionally established to be equal to or better than 80 percent of existing private, employer-sponsored plans. This was done to replicate or improve the coverage of working families and thus gain middle-class support. But because reform would enrich insurance coverage for many Americans, basic coverage for the under-65 population would exceed protections for the disabled and for those over 65 in the two areas of deductibles required before benefits and limits on out-of-pocket expenses would begin (referred to as "stop loss" protections). Medicare currently has no stop loss protection, while the Clinton plan provides a $1,500 limit per individual. Moreover, one of Medicare's weaknesses is its complicated deductible and cost-sharing structure. Beneficiaries now pay a $676 hospital deductible (with the chance of more than one such charge per year) and a $100 deductible for physician and ambulatory services. This compares to a $200 deductible for all services under the Clinton proposal.[21]

Thus, one of the great ironies of this plan is that despite $65 billion in proposed new spending on the Medicare prescription-drug benefit in the first five years of implementation, and about $64 billion in new monies for long-term care that would largely go to the Medicare population, there

will likely be complaints from beneficiaries over both the diminished generosity of Medicare relative to the under-65 plan, and new cost-sharing requirements for drugs, home health care, and laboratory services. Supporters of the Administration's proposal can rightly claim that there would be substantial improvements in benefits under Medicare; but this may afford little solace to those who will strenuously object to a less-generous benefit package for persons who need coverage the most.

The problem would be most visible for those turning 65 after health reform begins under the Clinton proposal. Becoming Medicare eligible would mean choosing between lower benefits under Medicare or substantially higher premiums in an alliance. This discontinuity between the alliance system and Medicare would dramatically highlight the two-tiered system created by the proposal. This awkward transition mechanism is a major weakness of the Administration's plan.

The Medicare "Wedge"

Medicare's current payment levels are lower than the amount allowed by most private insurers. Indeed, much criticism has been leveled at the current system over "cost shifting"—the process which results in some private payers being charged more to help compensate providers for the low payment levels of Medicare and Medicaid. Under the Clinton proposal, Medicaid beneficiaries would receive a health security card exactly like that given to workers; doctors and hospitals would receive the same payments for these patients regardless of who helps to pay for their insurance. Only Medicare would have a completely separate payment system. Because Medicare payments are now substantially below those for the private sector,[22] and since both Medicare and the rest of the system would experience stringent limits on spending growth, a payment differential would initially be "locked in place" at the outset of reform. This effectively institutionalizes "cost shifting."

The Administration contends that, because there is no current problem with providers refusing to take Medicare patients, this payment differential can be maintained until payments for the rest of the system are brought into line with Medicare.[23] It is anticipated that payments and fees in the alliance plans would be rapidly reduced, but it is difficult to determine with certainty what would happen. First, while the differential as a proportion of payment might remain the same, if both Medicare and other payment levels come down over time, providers may not view such changes as business as usual. Providers who feel squeezed from all sides may favor non-Medicare patients for whom fees are not as low. The current cost-shifting "cushion" provided by generous payments to private-sector providers would be reduced. In such circumstances, providers might not be as willing to overlook the differential.

Second, while limits on Medicare growth are intended to be slightly higher than limits on premium growth in alliance plans, the rates of growth are not very different. The Administration's stated goal is to reduce the differential to 0.5 percentage points. Consequently, it would take many years for this mechanism to yield similar payment levels. For example, if payments in Medicare were 80 percent of the level of the alliance sector, and Medicare payment rates rose at 6 percent per year compared to 5 percent per year for alliance plans, it would take about 25 years to equalize the payment levels.

It is even possible that the "wedge" between payment levels might acutally force them further apart. If this happens, specific reductions in payment levels for Medicare could be enacted into law, or cost containment in the rest of the system might be enforced by caps on the rate of premium growth so fees might not be as directly affected. Whether payment rates will converge depends on how alliance plans reduce costs. Some of the claims about obtaining savings in alliance plans emphasize greater efficiencies in the delivery of care and lower administrative costs. If that occurs, payment levels could remain higher for alliances than for Medicare indefinitely, and the percentage gap might actually widen. On the other hand, by obtaining provider discounts managed care plans have had great success in holding down costs.

The provider-payment differential creates a problem only if it affects patients' access to care. While an undetermined amount of discrimination may occur, the differential could reduce access to care if, for example, doctors refuse to accept new Medicare patients. And the entire health care system could be affected if hospitals that serve a disproportionate share of Medicare patients become trapped in such a tight financial bind that they are forced to close. If this occurs in underserved areas, all patients, not just Medicare beneficiaries, would suffer.

Meeting the Challenges

Even if Medicare remains largely intact after reforms in other parts of the system, the program needs to be coordinated with the imminent cost-cutting alterations in coverage for those under 65 years old. Including Medicare in reform could also offer an opportunity to treat all groups fairly and to reduce or eliminate distinctions based on age. These changes would substantially raise the cost of any reform option, however. If Medicare were included in overall reform, it would be reasonable to also raise con-

tributions from beneficiaries and, ultimately, to subject Medicare to the same cost containment methods used in the rest of the system.

The Benefits Structure

Ideally, the generosity of basic benefits under reform would be balanced between Medicare and the rest of the system. Prescription drug coverage, preventive services, and stop-loss protections are considered essential elements of reform under most plans, but not all of these would be added to Medicare. For example, the Clinton proposal would only expand coverage for prescription drugs.[24]

In the interest of fairness, Medicare enrollees should be treated the same as younger insured groups, perhaps not in terms of identical benefits, but at least through consistent criteria. And in instances where cost is an issue, it would be more equitable to cover fewer expanded benefits for everyone than to offer enhanced coverage only to the young, while arguing that a lack of funding makes the same package unavailable for Medicare beneficiaries.

One of the most troubling omissions for Medicare beneficiaries is the lack of stop-loss protection for limiting catastrophic burdens. Although stop-loss protection was undervalued by the elderly when it was provided in the Medicare Catastrophic Coverage Act (later repealed), it is part of any good insurance program and should be provided under Medicare. However, this is one area where a case might be made for a different limit for older persons than for the young on grounds of expense. A larger proportion of Medicare beneficiaries will exceed the upper limit on cost sharing than will nondisabled individuals under the age of 65, consequently, the same stop-loss limits would benefit more elderly than young persons. On the other hand, if stop-loss limits were expressed as a share of income, the elderly and disabled need as much or more protection than others in the U.S. Making treatment "consistent" may imply different rules depending upon one's starting assumptions. But the decision would be very important because of the high potential costs. For example, if the stop loss were set at $1,500 (the level in the Clinton proposal), Medicare costs would rise by at least $10 to $12 billion per year.[25]

Premiums and Cost Sharing

Expanding Medicare coverage to be consistent with coverage for the young would require additional resources. Therefore, it is not only reasonable, but equitable, to include the elderly and disabled in revenue raising for such expansions. At present, Medicare's required premium is 25 percent of the cost of Part B (physicians') services. If viewed in the context of all Medicare spending, premiums now total only about 10 percent of

costs.[26] Contributions by working families would be set at about 20 percent in the Clinton proposal. Thus, it may be reasonable to substantially raise the premium on the basic program, as well as to assess a premium contribution for any expanded benefits.

Asking that Medicare beneficiaries contribute to the program on the basis of ability to pay would represent another change consistent with health care reform for working-age families. Premium requirements under many proposals vary by income, and it makes sense to change Medicare in that direction as well. In fact, tying Medicare reform to health care reform for the under-65 population may lower one of the major obstacles to more progressive financing of Medicare. That is, one of the objections to the Medicare Catastrophic Coverage Act was that a small group of the elderly and disabled were being asked to subsidize the poor in their own group. When the entire population is involved and new financing mechanisms are being considered, it will likely be easier to make the case for fairness and spread the responsibility across all age groups so that no one group feels overburdened.

Medicare cost sharing is also imbalanced—for example, deductibles are unusually high for hospitals and nursing facilities and low for physician services. Hospital care deductibles do little to discipline use of services and, at $676 in 1993, the deductible is well above that found in private plans. A higher deductible on physicians' services (or a combined deductible) could help control the use of physician services and would not be unduly harsh. Cost-sharing for home health services, which are growing very rapidly, may be in order. In this area, even a cost-neutral change—raising some cost-sharing requirements while lowering others—would lead to better coordination with benefits for younger families and a more rational cost-sharing policy.

Improved protection for those with low and moderate incomes should occur simultaneously with changes in cost sharing. Those with modest incomes now have difficulty paying Medicare's cost sharing, thus reducing their access to the program. The Qualified Medicare Beneficiary (QMB) program now pays the premiums, deductibles and coinsurance of Medicare beneficiaries whose incomes are below poverty. By 1995, it will also cover premiums for those with incomes of up to 120 percent of poverty. QMB protection should extend beyond the poverty line, particularly if protections for younger families are established at 150 percent of the poverty level.

The Clinton proposal does provide some changes in what Medicare beneficiaries would pay, including adding coinsurance for home health care and laboratory services and a new income-related premium for persons with incomes over $90,000.[27] But these changes are part of the $124 billion in savings aimed at funding not only the new prescription drug

benefit but also expansions elsewhere in the system. More generous treatment of Medicare benefits might thus require even more dramatic increases in premiums and cost sharing.

Cost Containment Reforms

Cost containment mechanisms, to be effective and to reduce complexity in administration, ought to be applied equally throughout our health care system. The most obvious example is payment of providers. If there are limits on payment or volume of services allowed, the rules should apply equally across all payers of health care. This would mean that providers cannot shift costs from one source of payment to another. For example, as a result, providers would have to seek greater efficiencies in the provision of care, rather than charging private insurers more to make up for Medicare's restrictive payments. Or, in the case of the various proposals for reform which continue a differential between Medicare and other payers, the differential may lead to discrimination against Medicare beneficiaries. Cost shifting is undesirable currently and locking it in place for Medicare for the purpose of saving federal dollars does not make good policy sense.

On the other hand, moving Medicare immediately into a managed competition framework would create disruption and uncertainty that many advocates of reform wish to avoid. Consequently, most proposals leave out Medicare and assume it will continue to operate much as it does now. But, if we move to a system of managed competition for the working-age population where private insurers make arrangements with health care providers individually and with no overall controls, Medicare could be caught in the bind of being out of sync with the rest of the system. Its current low payment levels (from 25 to 40 percent below the current private sector) could mean that beneficiaries will find it increasingly difficult to obtain care from providers of their choice. Moreover, it is possible, for example, that many providers would join formal network delivery systems and thus limit their availability to Medicare patients. Medicare, as a fee-for-service model and with strict price limits on its providers, would subject elderly and disabled beneficiaries to a system very different from one that emphasizes organized delivery systems. Thus, even if Medicare is kept on a separate track, changes in the delivery system for the rest of the population will certainly affect how beneficiaries receive care as well.

The application of practice guidelines or limits on ineffective treatments will also be substantially more effective if done in a concerted way. Since such activities will be most effective if they change the attitudes of both providers and patients, efforts to influence practice must be viewed as a systemwide activity and not just a gimmick by one public program to

hold down its own costs. Patients are more likely to accept constraints if they feel they are equitably applied rather than being part of a group which has been singled out for special treatment. It is easier to make the case that a change will lead to better health care if it is applied to everyone. And certainly to hold down Medicare's costs over time will require close scrutiny of the *use* of services in addition to limiting the payment levels for providers.

Thus, one necessary step for successfully implementing the "next generation" of cost restraint will likely be the presence of more universal controls and coordination. Otherwise, Medicare may suffer. Including Medicare in the broad strategy for reform is likely a desirable approach, as long as it allows a gradual transition to managed care.

Administrative Streamlining

Another change that might initially add to Medicare's costs, but should improve the efficiency of the system over time, would be administrative streamlining. Simplified billing and administration of Medicare could substantially improve the program in the eyes of beneficiaries and providers. And, almost by definition, it makes sense to do this in conjunction with changes in the rest of the system. Medicare beneficiaries (along with all other Americans) could be given a card to be presented to providers. *All* billing could be done via the card so that beneficiaries would not have to file separately or handle multiple forms. The government could require that all doctors use the same forms for billing patients, thus ensuring uniformity. Imagine an environment in which the patient presents a card to the physician in the same way they now use credit cards. A simple computer link would provide information on how much would be paid by insurance and how much would be owed by the patient in the same way that merchants now run the card through a scanner to obtain approval. Separate insurance claim would be unnecessary—the physician would only have to complete a simple form signed by the patient concerning what services were delivered, and the system could track use of health services in a uniform way. It could track the plans and requirements of multiple insurers as well, much like the system that accepts credit cards regardless of type or issuer.

Beneficiaries could receive one or two bills per month and would pay just once per month for any cost sharing owed. Clear language would indicate what Medicare contributes—helping to underscore the substantial amount that Medicare provides—and what is paid by private insurers. Streamlining the billing process could lead to administrative savings, both in terms of lower health care spending, and by saving time and frustration for patients and health care providers.

Conclusion

At first glance, leaving Medicare largely out of the process of health care reform seems to make sense. The program already guarantees nearly universal coverage for all persons over age 65 and most long-term disabled persons. It is a popular and stable program. And since health care reform poses many daunting problems and promises to disrupt the system for many, why add Medicare at this time? The answer is that there undoubtedly will be enormous pressure from interest groups to add the same benefits guaranteed to everyone else and there are strong practical reasons to make cost containment efforts apply to everyone. The uneasy relationships that would result from keeping Medicare separate suggest a very unstable environment for achieving the broad goals of health care reform. But better integration of Medicare would make it more difficult to keep the costs of reform "off the books." Beneficiaries and/or taxpayers would have to be asked to directly contribute more. Unfortunately, the current environment for reform may preclude a careful debate over the dilemma that Medicare poses for reform.

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ARE PRIVATE INSURERS REALLY CONTROLLING SPENDING BETTER THAN MEDICARE?

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The Urban Institute

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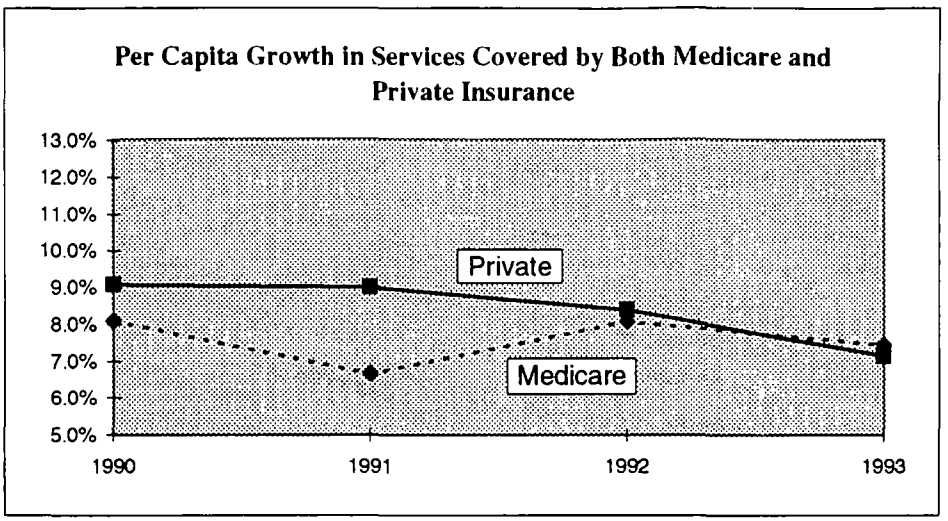
Executive Summary

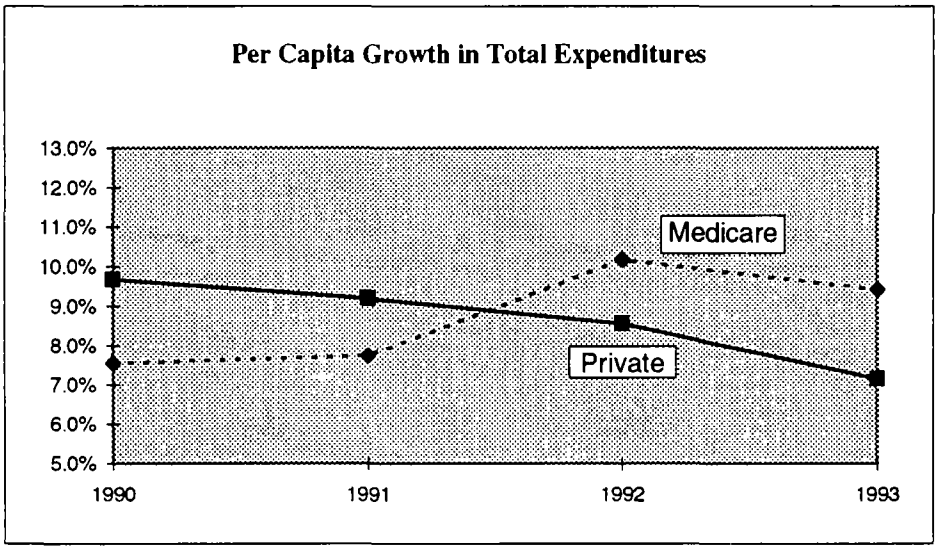
Reducing the rate of growth of the Medicare spending is an essential policy goal both for putting the program on firmer financial footing and for achieving the budget savings outlined in the recently passed budget resolution of the Congress. The targets established in that resolution--of $270 billion in savings over the next seven years--will require major changes in the Medicare program. In searching for ways to achieve savings, some have suggested adopting principles developed in the private insurance market.

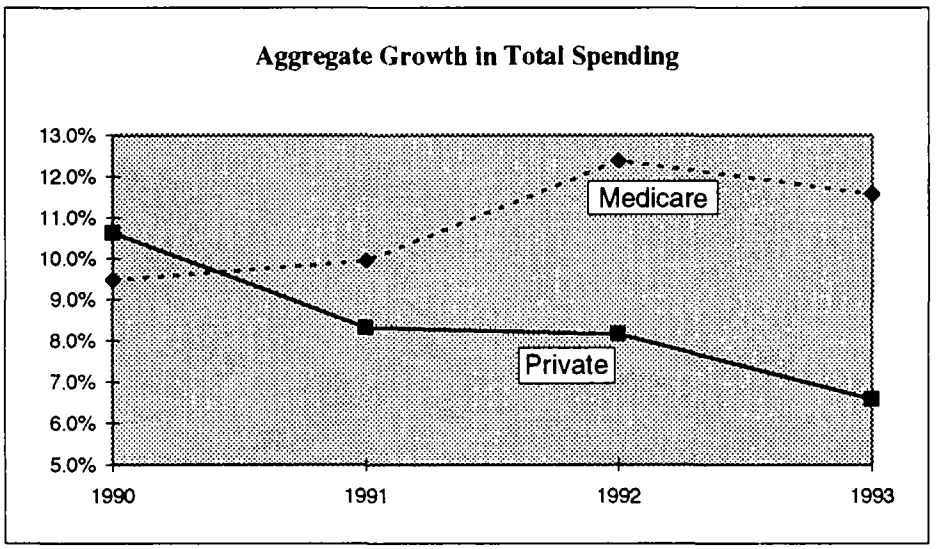
Indeed, many Americans seem to take for granted claims that Medicare spending is out of control and do not question comparisons suggesting large differentials between Medicare and private insurance spending growth. However, these comparisons prove difficult to interpret because the private insurance estimates use data from surveys of employer health plan costs that are often affected by shifts in enrollment across types of plans as well as changes in costs sharing, service coverage and utilization review that are hard to quantify. Instead, we use the National Health Expenditure (NHE) accounts data which capture spending by category of service for both Medicare and private insurance and these data allow us to make consistent adjustments. It is important to calculate growth per capita and to limit the data to categories where both Medicare and private insurance provide coverage of services. While these are simple adjustments, they have a dramatic impact on the comparisons shown in the accompanying chart. Viewed over the years 1990 to 1993 (the last year when the full NHE data set is available), Medicare spending grows substantially slower than spending from private insurance until 1992, then private insurance gains a 0.3% advantage.

Looking down the chart, it is easy to see how much the numbers can differ depending upon how growth is measured. On a per capita basis, Medicare still fares well as compared to private insurance even when all categories of spending are included, but in the last two years, its growth is higher than the private sector. This differential largely occurs because home health services and skilled nursing services (both of which are less important to those covered by private insurance) have been growing very rapidly under Medicare.

Comparison of Growth Rates







The bottom graph shows aggregated growth rates--the least desirable way to compare Medicare and private insurance, although it is often used (Freudenheim 1995). Since 1990, the numbers of persons covered by private insurance has been dropping, while the number of Medicare beneficiaries has grown by about 2% per year on average. In that case, much of the positive differential between private insurance and Medicare aggregate spending growth is driven by how many people receive coverage, certainly not a factor that should be included in any measure of how well the private sector is controlling spending nor one that is often acknowledged.

But even with the consistent data methods we use in making comparisons, several other factors need to be kept in mind in thinking about how much Medicare can benefit from adopting the techniques of the private insurance industry. For example, one way in which private insurers are slowing growth rates is to pay less for services than in the past. But since the level they start from is much higher than the levels that Medicare already pays, this source of savings would largely be unavailable to Medicare. For example, government studies show that in 1993 hospitals receive payments equal to 89 percent of their costs of treating Medicare patients as compared to 129 percent of their costs from private payers. Medicare was well ahead of private insurers in realizing it could benefit from low levels of hospital and physician payment.

Finally, this study uses data on actual experience and thus does not capture information for 1994. Preliminary numbers for 1994 growth rates do indicate a stronger showing for private insurance relative to Medicare. But we do not yet know whether such results can be sustained over time since some of the savings being achieved in the private sector represent one time gains as employees shift from expensive to less expensive plans. While Medicare could also achieve such savings, they are likely to be short term in nature and, thus, would not necessarily result in the low rates of growth needed year after year to achieve the federal budget targets set for Medicare.

INTRODUCTION

Part of the current debate over the federal budget focuses on the rapid growth in Medicare spending. Further, Medicare's growth is being contrasted unfavorably with some estimates of growth in private health insurance spending.[1] The argument becomes that "the Medicare program could be rescued if only the Government would adopt some of the cost controls that employers have imposed on their workers under the banner of 'managed care'" (Freudenheim, 1995).

Before concluding that enormous savings are readily available by simply moving beneficiaries into private plans, however, it is important to take a closer look at the numbers people cite and what they mean. How fast is Medicare growing? Why is Medicare growing so rapidly? Is the rate of growth so different between Medicare and the private sector? Many Americans seem to take for granted claims that Medicare is out of control and do not question comparisons suggesting large differentials between Medicare and private insurance. But careful answers require consistent data between the public and private sectors, a reasonable time horizon for meaningful comparisons, and careful discussion of what the various numbers mean. At worst, the comparisons may reflect an "apples vs. oranges" problem in which comparisons are made on noncomparable data. But even when total comparability is not possible due to data limitations, it is still useful to look closely at Medicare and the private sector for some lessons for the future.

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[1]See, for example, Hage and Black, 1995; and The Heritage Foundation, 1995.

This paper begins with a discussion of some of the most commonly cited numbers on the growth in Medicare and private insurance, finding a broad array of differences that make comparisons potentially misleading. We then turn to a more consistent set of comparisons based on the National Health Expenditure data that allow us to examine changes over time in a number of subcategories of health care services. We conclude that growth rates between private insurance and Medicare have actually been quite similar--a very different finding than casual comparisons often suggest. Moreover, growth rate comparisons need to be viewed cautiously given the different payment levels for services under Medicare as compared to private insurance. Sharp declines in the private sector may reflect discounting off of a very generous level, for example. Finally, we conclude with a look at how changes in the mix of persons covered by Medicare and private insurance might affect rates of growth over time.

COMMON PRIVATE SECTOR COMPARISONS

When people try to assess the size of Medicare spending growth relative to the private sector, they are typically drawn to the results from two national employer-based surveys, one sponsored by Foster Higgins (1995) and the other by KPMG (1994). Although there are differences in the sampling frames for these two surveys, both are trying to estimate the change in the total cost of the employer-sponsored health insurance package, including both the employers' and employees' contributions. Foster Higgins estimates a 1.1% reduction in health benefits costs per employee between 1993 and 1994, while KPMG estimates a 4.8% increase. The KPMG number is probably more useful because it represents the average

change in costs for the same plans at the same employers. Thus, it is essentially a genuine year to year "apples to apples" comparison.

The Foster Higgins estimate, on the other hand, is hard to interpret because of the way it treats retiree health costs.[2] In addition, the 1.1% reduction is greatly influenced by shifts in enrollment among types of health plans. In fact, Foster Higgins explicitly cautions that a large part of this "favorable experience in 1994 is a one-time savings due to moving employees from a higher cost plan to a lower cost plan." What this means is that the underlying growth rate in health plan costs may have changed imperceptibly, but that the downward shift in the cost of an average plan is producing a short-term adjustment rather than a long term trend.

A simple example based on premiums and the distribution of covered individuals across plans similar to that in the Foster Higgins data highlights this point. Suppose that there are two types of health plans in 1993--indemnity and managed care --and that covered individuals are evenly split among these plans. In addition, assume the indemnity plan has a premium of $4000 and the managed care plan a premium of $3500 in 1993. If the premium for the indemnity plan increases by 10 percent in 1994, the managed care plan premium increases by 5 percent, and the insured remain evenly split, then the average plan costs would change from $3750 to $4038, an increase of 7.7 percent. However, if the insured shift among plans in the direction of the lower cost managed care plan so that in 1994, say, 35 percent are

[2]The Foster Higgins data shows that fewer firms provided retiree benefits in 1994 than in 1993. This would tend to bias the change in health plan costs per active employee (the widely-cited 1.1 percent reduction downward by reducing aggregate health plan costs via the retiree portion without necessarily lowering the number of active employees covered.

in managed care and 65 percent in indemnity, the average plan costs increase to only $3929, or by 4.8 percent. Thus, as individuals shift to lower cost plans, overall health care cost may grow at rates below those reflected in the experience of any single health plan. Moreover, when the shift toward lower cost plans stabilizes, the annual change in health care costs will likely increase.

Can either of the Foster Higgins or KPMG estimates of private spending growth be used as a basis for comparison to Medicare? For several reasons, these estimates of private premium growth per employee may not be comparable to Medicare program spending growth. Since these surveys measure private spending from the perspective of a health plan's costs, their results will be affected by changes in health plan characteristics. Changes in deductibles, copayments, service coverage, and utilization review will all affect these estimates of spending growth. Changes as a result of some of these plan characteristics might be viewed as a "success" in holding down health care spending (e.g., utilization review), but others make claims about slowing spending difficult to interpret. For example, if increasing deductibles and copayments lower health premiums over time by shifting costs to patients, we should not conclude that the underlying growth in total health care spending has necessarily slowed.

Unfortunately, it is difficult to determine just how much private sector cost sharing has changed. If health plans were still generally traditional indemnity insurance, it would be easier to correlate increasing deductibles and copayments with lower premium growth. However, in a world of rapidly changing types of plans, new cost sharing structures are being developed and the implications of these changes are more difficult to assess, particularly on a

year-to-year basis. For example, KPMG data suggest that deductibles have been increasing in Preferred Provider Organization (PPO) and Point of Service (POS) plans--both for in-plan and out-of-plan users. While this implies that PPO and POS premium growth is lower than it would have been with constant deductibles, it is impossible to determine the actual average cost sharing within PPO and POS plans since that depends on the extent of in-plan or out-of-plan use and such information is not reported in the current surveys.

Medicare, on the other hand, has maintained a fairly stable schedule of deductibles and copayments, particularly under Part B where most of the cost sharing occurs.[3] The Part B deductible, originally $50, is still only $100. The copayment for Part B services has always been 20 percent. On the hospital side, cost sharing, particularly for the deductible has risen steadily over time, but it remains a small share of total cost sharing. Overall, the share of acute care spending covered by Medicare has remained relatively constant since the 1970s (Moon, 1993).[4]

In addition, although the core set of services covered (e.g., physician and hospital care) by private plans might appear reasonably stable over time, plans may add or subtract benefits such as dental care, vision services and prescription drugs annually. Mental health and substance abuse benefits represent another area where employers have been establishing

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[3]Part B of Medicare covers physician and other ambulatory services, while Part A covers hospital, skilled nursing and home health care.

[4]The presence of private supplemental coverage and the Qualified Medicare Beneficiary program means that many of the elderly have nearly first dollar coverage for acute care services. This likely affects the level of Medicare spending, but not necessarily the rate of growth over time since the share of the elderly with such protection has remained relatively constant.

special limits (Foster Higgins, 1995). Thus, if services paid through private health plans have been reduced, insurance is effectively a different product than it was several years ago and growth rate figures may thus be misleading.[5] In contrast, we know that Medicare's coverage has changed little, with the exception of home health and skilled nursing services where regulatory control and other limitations have alternatively eased and tightened at various points in time.

An area where changes in the private sector could legitimately be used to tout success is control over the use of services. Private plans differ markedly from Medicare in their adoption of utilization review, including pre-admission certification for non-emergency care and case management. The goal of utilization review is to reduce the volume of unnecessary services and hence to make the delivery of care more efficient. HMOs and other new forms of managed care have moved aggressively into these areas of control. Although Medicare has some review activities that occur through Professional Review Organizations (PROs), it does not have the prospective review employed in the private sector. Although KPMG data show that the share of plans with utilization review has been fairly stable over the last few years, there is little hard evidence to indicate how the criteria upon which this review is based may have changed. If these criteria are becoming stricter, they could explain some of the slowing of the growth in spending in both the Foster Higgins and KPMG surveys.

Although changes in cost sharing, service coverage, and utilization review can all lead to a short-term slowdown in health care spending growth, they do not alter the determinants

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[5]Such changes are more likely to show up as long term trends, however, and hence may also not be very important for annual growth rates.

of the longer-run trends. Long-run trends in health care spending can only be lowered by slowing the rate at which new technologies are developed, adopted, and used or by continued reductions in the overall volume of service use. This would imply both an evolution of a new set of standards of care and lower expectations about the ability of the system to address health care needs.

TRENDS WITH NATIONAL HEALTH EXPENDITURE DATA

To effectively compare Medicare and private insurance, it is important to use a consistent data base. For this, we use the National Health Expenditure (NHE) accounts. Produced each year by the Health Care Financing Administration, these data draw on actual public spending and a variety of surveys of the private sector's health care providers to give detailed numbers of spending by type of service and by payer (Levit et al., 1994). While the data on payments by Medicare and private insurance plans in the NHE accounts do come from different sources, there is an attempt to produce numbers that conceptually track the same components of spending for payers. These are the best available data for this purpose.

Further, since the number of Medicare beneficiaries is growing more rapidly than the number of persons covered by private insurance, a first step in this analysis is to focus on per capita numbers. This is essential because the number of enrollees in Medicare has been rising steadily while the absolute number of enrollees in private insurance plans has been falling since 1990.[6] Without such an adjustment, aggregate Medicare spending would grow

[6]Since 1982 Medicare's beneficiary growth has averaged about 1.9 percent per year (Committee on Ways and Means, 1994).

more rapidly than aggregate private insurance spending even if both payers experienced the same growth in costs per enrollee.

If we begin with the standard overall personal health expenditure category, per capita growth rates in Medicare and private insurance spending for the most recent year, 1993, were 9.5% and 7.1% respectively--important differences, but not on the order of two-to-one (or more) as has sometimes been suggested.[7] Preliminary projections by the Health Care Financing Administration indicate a wider difference for 1994 of 9.1% and 4.6%.[8] These savings in the private sector relative to Medicare for the past two years may prove to be an important turning point. But we do not yet know whether they can be sustained over time, since two years represents a very short period for tracking health care spending. In terms of trends, Medicare fares very well over the last decade as compared to the private sector in which it bested the private sector in seven of the last ten years (See Chart 1).[9]

But it is somewhat misleading to look only at overall personal health expenditures since Medicare and private insurance often cover very different services. For example, home

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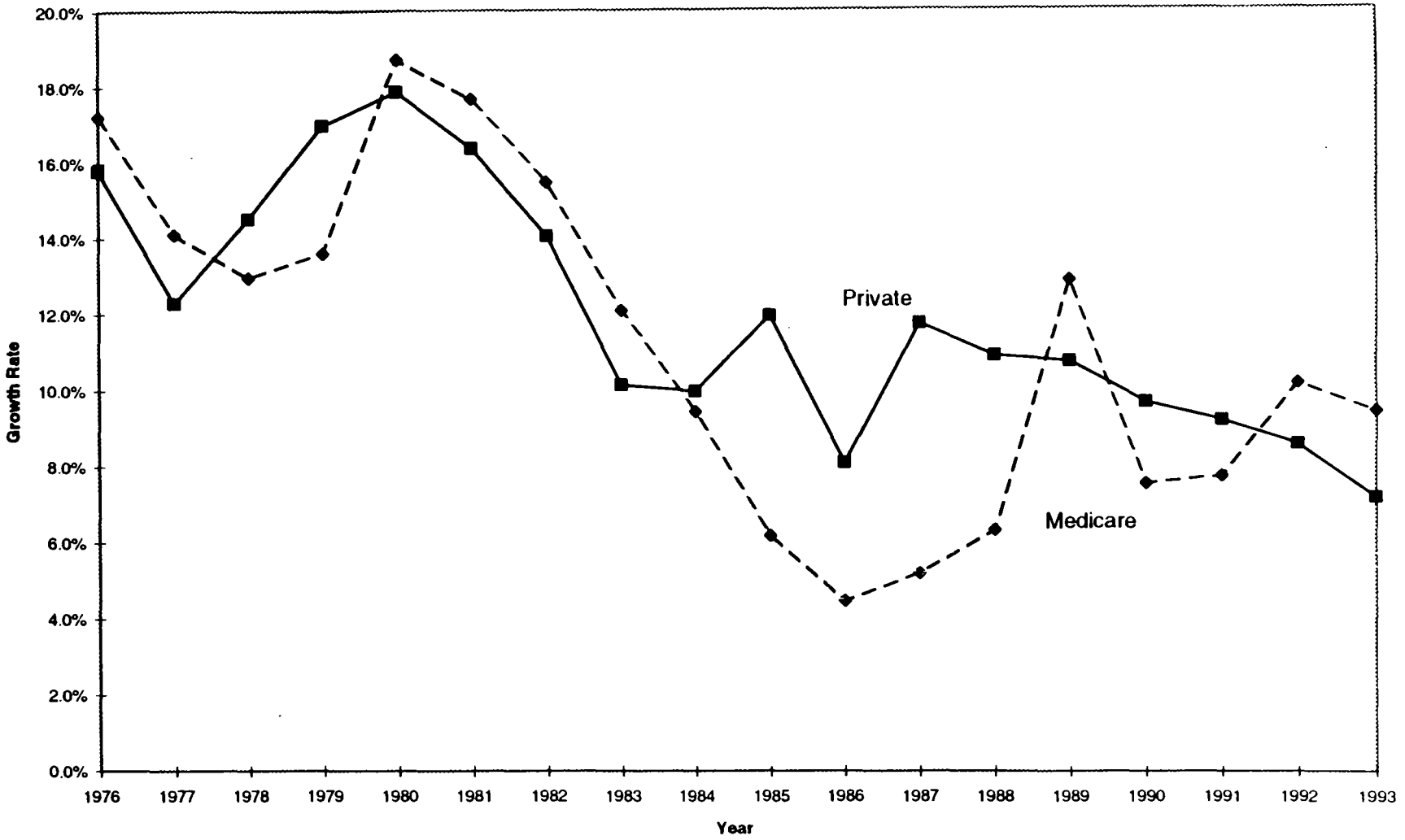
[7]For example: "while private health insurance is not rising on average this year because of the competition, expenditures for Medicare is (sic) rising 10.5 percent" (Burrelle's Information Service, 1995).

[8]Arguably, there might be some interest in also deflating Medicare and private insurance spending trends to net out differences in price growth. However, there is legitimate disagreement regarding the appropriate price deflators to use with these data (see Levit, et. al, 1994 and Huskamp and Newhouse, 1994). Therefore, we choose to report all trends in nominal terms.

[9]Moreover, 1989 should be treated as an anomalous year since the short-lived catastrophic program led to modest increases in hospital spending, but a dramatic 261% growth in skilled nursing spending. It is also interesting to compare Chart 1 with Appendix Chart A which shows the same growth rates on an aggregate rather than per capita basis and illustrates how important just this one adjustment can be.

Chart 1

Per Capita Growth Rates of Total Personal Health Expenditures
1976-1993



health care and skilled nursing services--which are two of the fastest growing parts of Medicare--are much less important for younger families covered by private insurance. If these two benefits were truly post-acute care services and hence served as substitutes for hospital care, it might still be important to include them with other acute care coverage. But a post-acute care response to hospital changes should have occurred between 1985 and 1988 (when hospital growth was lowest). But both SNF and home health services showed little or even negative per capita growth during that period (See Appendix Table C). Instead, much of the growth of these benefits has occurred since 1989 and reflects an expansion of Medicare into long term care types of services.[10]

And, on the other side, private insurance often includes some prescription drug coverage, and sometimes dental insurance, while Medicare does not. Consequently, to offer a more accurate picture of differences in spending growth between these two payers, we focus on those services where both Medicare and private insurance play a substantial role. Our efforts are limited by the fact that the National Health Expenditure (NHE) numbers combine a number of categories that we would like to be able to disaggregate.[11] For example, vision

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[10]In the case of skilled nursing facility services (SNF) a court case in 1988 and then the Medicare Catastrophic Care Act in 1989 loosened substantially the restrictions on receipt of these benefits (for example, by eliminating the three day prior hospital stay requirement). Skilled nursing benefits expanded substantially, in part substituting for Medicaid long term care (Liu et al., 1995). A similar legal challenge in 1989 for home health services seems to have opened the door for some beneficiaries to receive large numbers of visits--particularly for nonskilled home health aide services (Kenney and Moon, 1995; Bishop and Skwara, 1993).

[11]In addition, 1994 numbers are only available for total spending, so the disaggregations we show below cannot yet be updated for 1994. When we are able to do so, the numbers will likely show a more favorable tilt to the private sector. Finally, it is not possible to pull out insurance that supplements Medicare ("medigap"), but if it were that would result in an

Table 1

Share of Total Personal Health Expenditures

Health Expenditure Categories	Medicare		Private Insurance	
	1975	1993	1975	1993
Consistently Covered Services				
Hospital Services	73.3%	61.3%	62.0%	45.6%
Physician Services	21.5	23.0	29.1	32.6
Other Professional Services	1.3	3.7	1.3	6.1
Vision and DME	0.8	2.5	0.6	0.3
Other				
Nursing Homes	1.9%	4.1%	0.3%	0.7%
Home Health	1.2	5.3	0.2	1.0
Drugs and other Nondurables	0.0	0.0	3.4	7.1
Dental Services	0.0	0.0	3.2	6.5

Source: National Health Expenditures, Health Care Financing Administration.

care and durable medical equipment (DME) are combined in the NHE data. The first of these is less well covered by Medicare while DME represents an area of considerable growth for Medicare in recent years.

Nonetheless, we concentrate much of our attention on four of the NHE categories: hospital services, physician services, other professional services, and vision/DME services. Altogether these services accounted for 90.6% of what Medicare covered in 1993 and 84.7% of what private insurance covered in that year. Home health and skilled nursing care made up the rest of Medicare services, while they accounted for only 1.7% of private insurance coverage. Drugs and dental services account for the rest of private insurance coverage not reported here and were negligible for Medicare. Table 1 indicates the importance of each of these categories to Medicare and private insurance.

Two years of data are presented in Table 1 to also illustrate how these shares have shifted since 1975--another factor which is important to understanding growth in spending as well. Over time, for example, hospital services have become much less important to Medicare while all other categories of covered services have increased. The same hospital trend holds for private insurance, although hospital services have never been as important as under Medicare. The share of private insurance spending for drugs and dental services has more than doubled, two areas not covered by Medicare.

By concentrating on the first four categories of Table 1, we are able to examine spending growth across the two sectors for a more consistent set of covered services. Medicare's spending growth in 1993 is much closer to that for private insurance among this

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improved estimate between Medicare and private insurance for younger families.

set of services. Per capita numbers for the four combined NHE categories yield average rates of growth of 7.4% for Medicare versus 7.1% for private insurance. And, when comparing the patterns of these two sectors over time, Medicare does better than the private sector in eight of the last ten years (Chart 2). In some of those years, particularly during the late 1980s, Medicare's growth rates are substantially below those for private insurance.

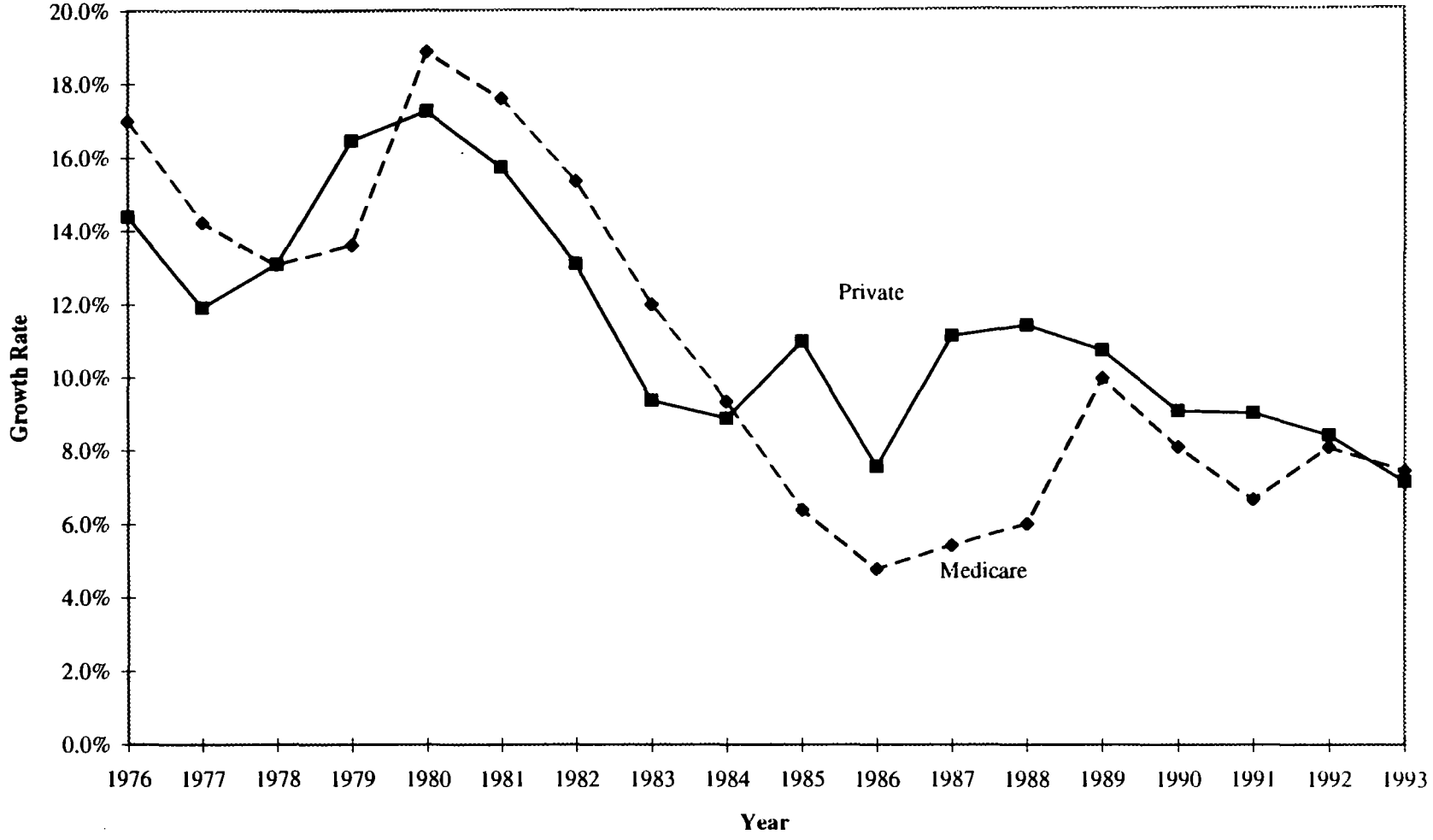
Even more interesting patterns emerge if we look at each of the four service groups separately. For both hospital and physician services, the effects of changes in Medicare's payment policies are quite clear. Rates of change in spending for hospital services (Chart 3) were comparable for Medicare and private payers prior to 1985. The last two years of this period cover the start-up period for Medicare's Prospective Payment System (PPS) during which Medicare rates were set quite generously. Between 1985 and 1988, Medicare corrected for these initially high payment rates by establishing very low update factors and kept hospital spending growth well below that of private payers.[12] This caused hospitals' PPS margins to fall from over 14 percent in 1985 to 1.4 percent in 1989. After 1988, Medicare continued with growth rates that were closer, but still below, private payers in all years except 1992.

In contrast to the PPS, Medicare approached changes in physician payment policies in a more piecemeal fashion during the 1980s. It was not until 1992 that comprehensive physician payment reform was implemented. Nevertheless, the effects of the 1980s policies can be seen in Chart 4. Until 1983 Medicare and private payer rates of change in physician

[12]The increase in the growth in privately-insured hospital spending may be due to cost-shifting, a revenue-enhancing strategy through which hospitals, as a whole, offset losses on some patients by earning more on others. However, there is wide variation across hospitals in the ability to undertake cost shifting (ProPAC, 1992).

Chart 2

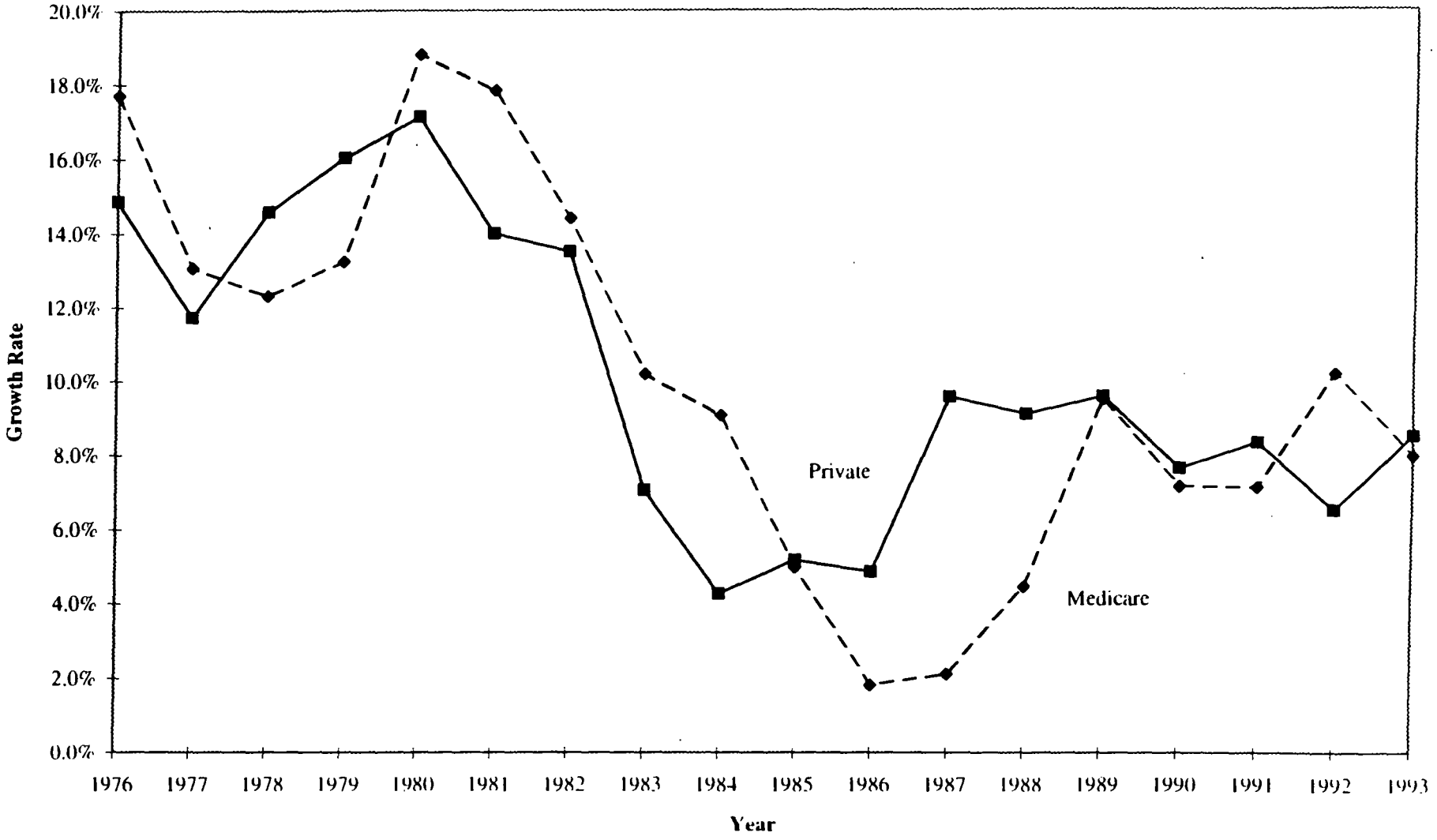
Per Capita Growth Rates of Services Covered by Both Medicare and Private Insurance 1976-1993



Source: National Health Expenditure Data,
Health Care Financing Administration

Chart 3

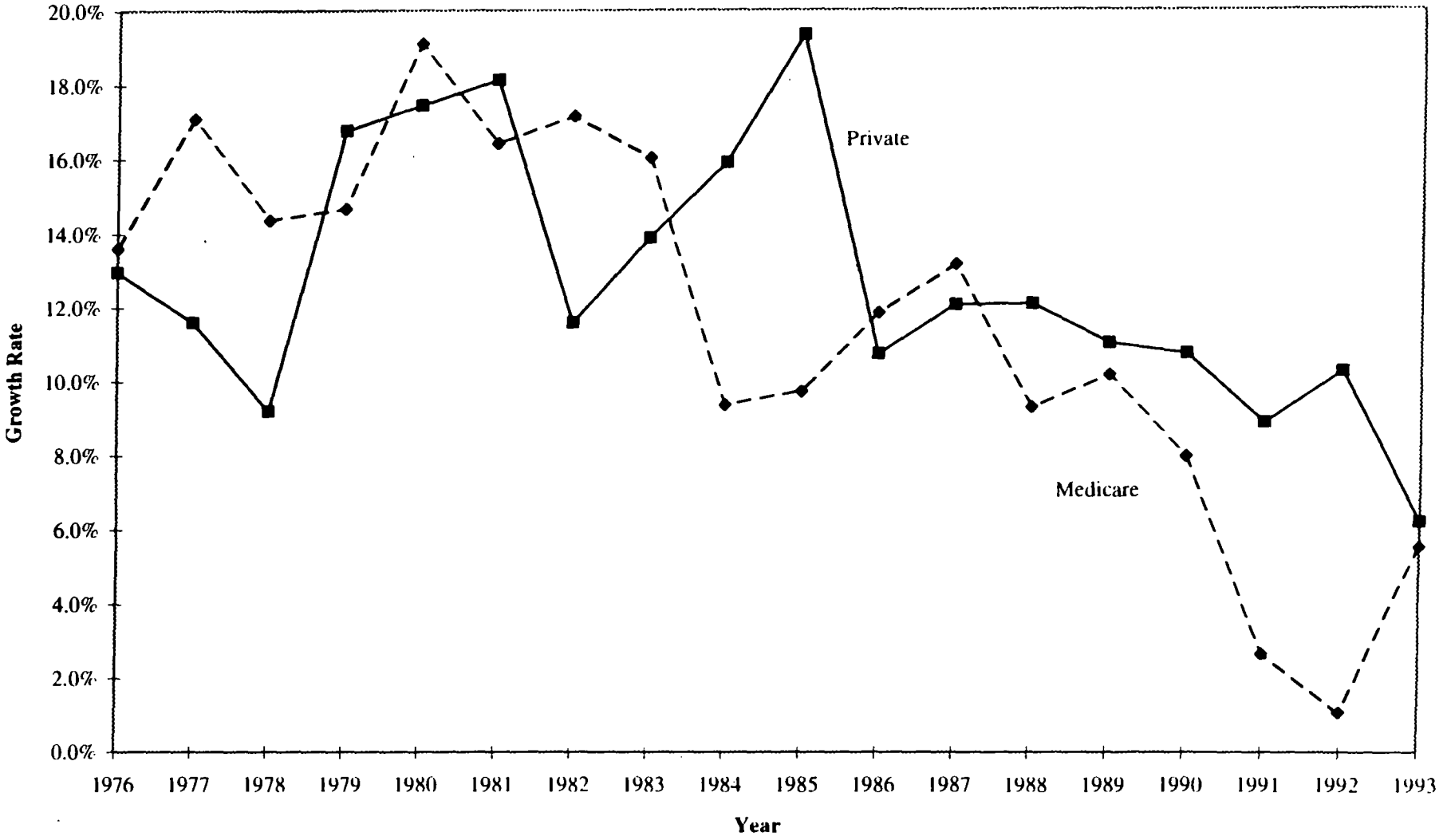
Per Capita Growth Rate of Hospital Services
1976-1993



Source: National Health Expenditure Data,
Health Care Financing Administration

Chart 4

Per Capita Growth Rate of Physician Services
1976-1993



Source: National Health Expenditure Data,
Health Care Financing Administration

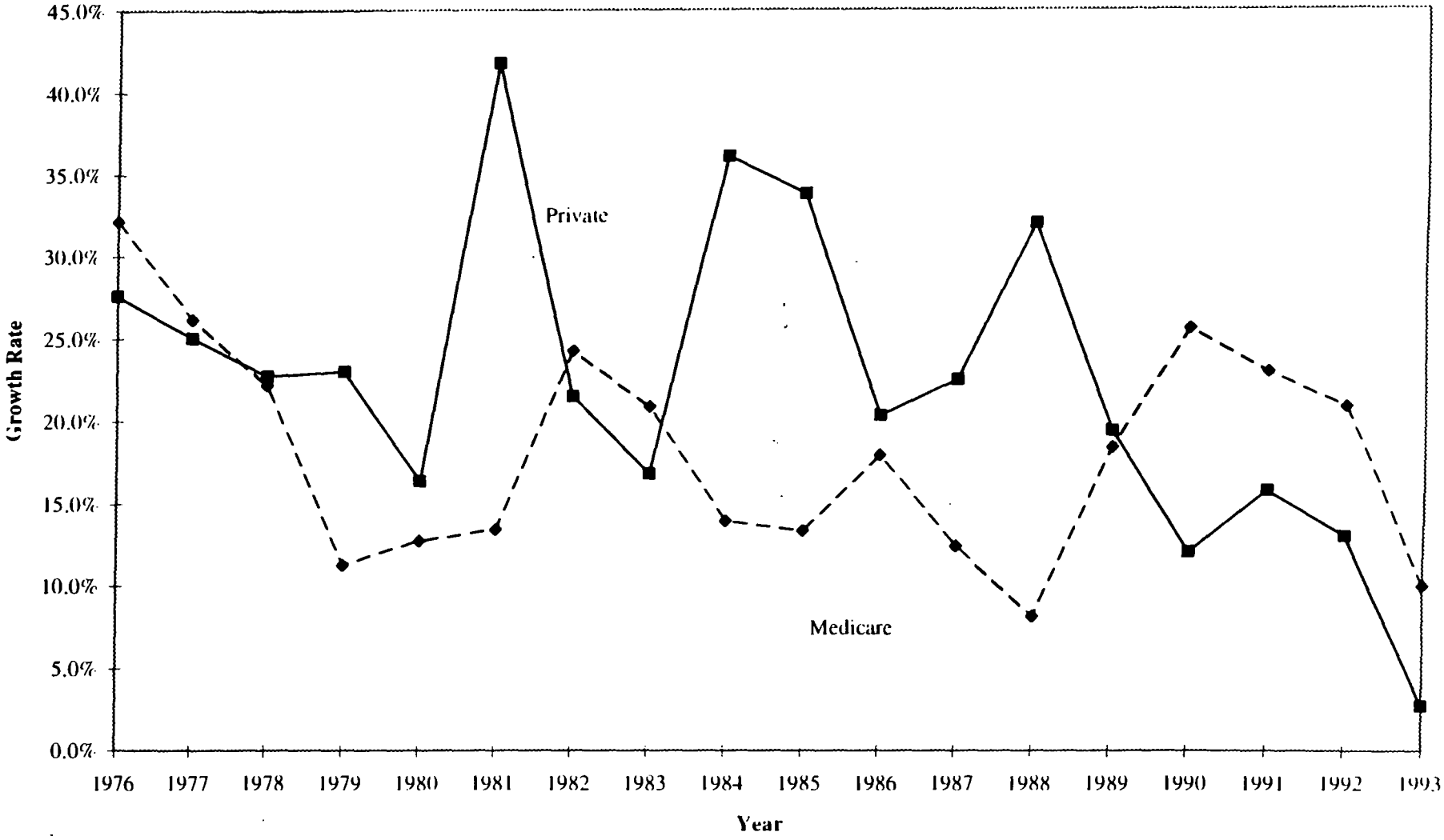
spending were bouncing around; in some years Medicare was higher and vice-versa. However, in 1984 Medicare froze physician fees for almost two years and achieved a dramatic slowdown in spending growth relative to the private sector. Once the freeze was lifted in 1986, Medicare spending growth exceeded that of private payers for two years. By 1988, there was general agreement about the likely shape of the reforms that would ultimately take place in 1992.[13] As such, Medicare gradually began to move fees for specific services toward the reform target, while keeping overall fee growth to moderate levels. These concerted efforts allowed Medicare physician spending to grow at lower rates than private payers in every year starting in 1988.

Other professional services constitute another category where both Medicare and private insurance provide substantial coverage (Chart 5). These include spending for services provided by independently practicing licensed health care practitioners other than physicians and dentists. Such professionals include private duty nurses, psychologists, and podiatrists. They also cover services in freestanding outpatient clinics such as mental health and rehabilitation centers. After substantial declines earlier in the rates of growth in these services, they again picked up in the early 1990s under Medicare. The patterns are quite different for private insurance. Rates of growth were much higher there than under Medicare for most of the period before 1990. Since then, there has been a dramatic decline in private sector growth. Could this reflect some of the tightening on services such as mental health by

[13] The basic notion was that fees for procedures and diagnostic testing were "too high" relative to fees for evaluation and management services and that this could be corrected if a payment system were established under which relative fees were based on relative resource costs. This objective was achieved through adaptation of the Resource-based Relative Value Scale developed at Harvard University (Hsiao, et. al, 1979).

Chart 5

Per Capita Growth Rate of Other Professional Services
1976-1993



Source: National Health Expenditure Data,
Health Care Financing Administration

private plans? If costs of care are shifted to consumers, there should be a concurrent increase in out-of-pocket spending in this category in the 1990s. Rates of growth in out-of-pocket spending for the services have not, however, shown a consistent trend that would substantiate a shifting of burdens onto consumers.[14] It may be, however, that restrictions have occurred in this area without shifting costs onto patients.

Vision services and durable medical equipment constitute the last area of comparison between private plans and Medicare. In looking at Chart 6, it appears there are few consistent patterns. Perhaps most impressive is the steady decline in the rate of growth of spending by private insurance in this area since 1987. Again, an examination of out-of-pocket spending growth does not indicate any clear evidence of shifting of burdens onto individual consumers in this category.

The excluded categories of spending are also interesting (as shown in Appendix Table C). Part of the reason that Medicare looks so much better than the private sector in recent years within our framework is the exclusion of SNF and home health services. These two areas have grown very rapidly under Medicare, particularly since 1989, largely as a result of a relaxation in regulatory oversight.[15] But our choice of categories for inclusion in Chart 2 does not work exclusively in the favor of Medicare. The excluded categories have grown

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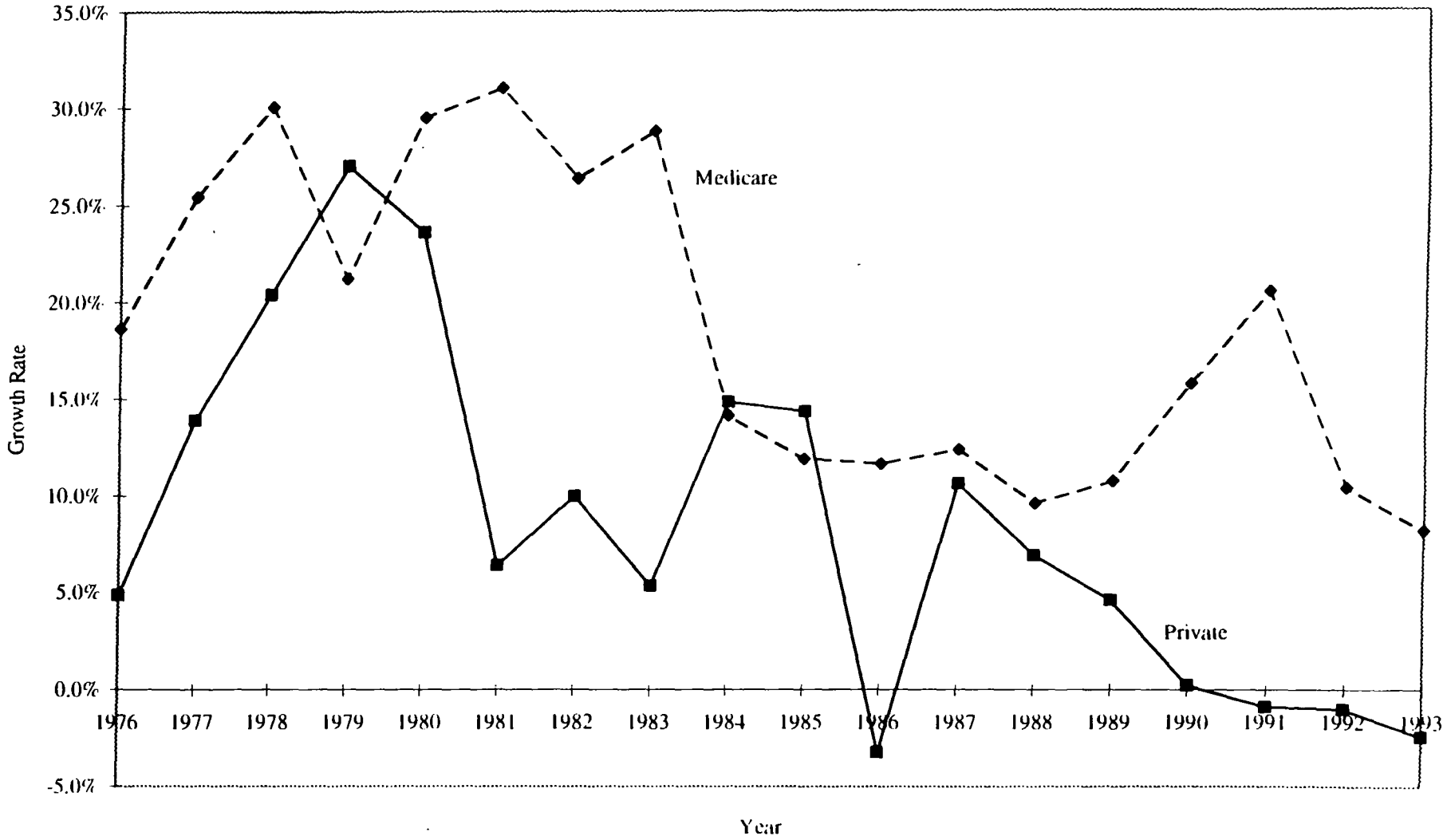
[14]It is important, however, to view this with caution since we are not able to link the rise in out of pocket spending to those with private insurance. Rather our out-of-pocket numbers refer to all Americans. More detailed databases would be needed to determine whether the "success" of private plans in this spending category is merely a shifting of burdens onto consumers.

[15]And, 1989 was an anomalous year for skilled nursing care under Medicare. Benefits were expanded and cost sharing changed for that year only as a result of the Catastrophic legislation.

Chart 6

Per Capita Growth Rate of Vision and DME
1976-1993



Source: National Health Expenditure Data,
Health Care Financing Administration

faster than the included ones for the private sector as well. In particular, private insurance spending on drugs and other nondurables have grown at a per capita rate greater than overall private insurance spending in every year since 1981. Dental services also grew rapidly in the early years, but their growth rates have slowed substantially since then.

PAYMENT LEVELS AND GROWTH RATES

Despite the low rates of growth private insurers have achieved in recent years, it is still the case that, on average, they pay more than Medicare for most services in most areas of the country. Given the current direction of the policy debate, an obvious question that would be useful to answer is "what would it cost to insure Medicare beneficiaries through private health plans?" While this is a complex question to answer precisely, based on what is well known about what private payers pay for hospital and physician services, Medicare payments would rise substantially if the program paid for these services at average private rates. The Prospective Payment Assessment Commission reports that revenues from private payers were 29 percent above hospital costs in 1993, down from 31 percent above costs in 1992. Although there may be reasonable expectation of a continued decline, it would take many years for these rates to converge to Medicare payment levels, which are, on average, 11 percent below the costs of treating its beneficiaries (ProPAC, 1995).

A similar pattern exists in the physician services market. Based on 1993 data, the Physician Payment Review Commission estimates that Medicare fees were, on average, 38

percent below those of private payers (PPRC, 1995).[16] Although the precise size of this differential may be somewhat sensitive to the methodology used in the calculation (e.g., Miller, Zuckerman, and Gates, 1993), all studies suggest that average Medicare physician fees are below those of private insurers. Obviously, many Preferred Provider Organizations are entering into contracts with physicians that contain fees well below those that existed under payment systems based on, say, "usual, customary and reasonable" charge screens. A recent Urban Institute study shows that PPO discounts can be substantial--averaging 24 percent for one large national insurer in 1993 (Zuckerman and Verrilli, 1995). However, even with these discounts, Medicare's average physician fees were still about 30 percent below those paid by this insurer's PPO.

The role these payment differences play in understanding the National Health Expenditure analysis presented above is important. The differentials imply that some part of the success that private insurers have achieved in controlling spending in the last two years is the result of negotiating discounts from historically-high provider payment rates. Given the levels that these rates were starting at and the excess supply of provider capacity in many areas, it is not surprising that large discounts can be obtained, enabling large reductions in spending growth.[17] However, the spending growth slowdown that would be observed as a

[16] The PPRC analysis of private fees uses a weighted average of fees from both indemnity and PPO payers, suggesting that it is not a worst case scenario for Medicare fee generosity.

[17] However, our analysis of NHE data through 1993 does not suggest that private insurers have slowed spending growth below Medicare for comparable sets of services. Further declines may be noted in the future.

result of this realignment of prices would represent only a transition from a high-level of spending to a moderate-level of spending, with little impact on underlying long-term trends.

CASE MIX DIFFERENCES AND SPENDING GROWTH

Not only are the populations served by Medicare and by private insurance quite different, but they may be changing over time in ways that affect rates of growth. For example, for the last few years, fewer people are being covered under private insurance each year; if those losing coverage have health problems and thus cannot get insurance, then their exclusion would move growth rates of private insurance spending downward. On the other hand, if those who drop coverage are younger workers who feel that coverage is not worth the premiums they would have to pay, this would shift growth rates upward. Unfortunately, data on the health status of persons with private insurance coverage is almost nonexistent so we are only left to speculate about the extent to which the reported growth rates are reflecting differences in the cost of insuring a changing mix of patients.

Medicare data, on the other hand, do allow us to look at what impact a changing composition over time of at least age and a few other factors have on the costs of insurance. As part of the analysis for this project, we examined whether the aging of the Medicare population contributes substantially to Medicare's growth rates. A positive finding in this regard would suggest that Medicare spending growth should be higher than that for the rest of the population even after controlling for all other factors. We found that the aging of the population covered by Medicare does add to the rate of growth of spending since the

proportion of oldest and sickest beneficiaries is rising, but by less than might be expected.[18]

Specifically, we compared Medicare spending in 1977 and in 1992 by detailed age groupings for those aged 65 and above and for the disabled as a group. We then considered whether overall spending would have been lower in 1992 if we allowed average spending for each age group to change but held the share of the population in each group constant at the 1977 level.[19] This essentially allows us to consider what spending would look like if the age distribution of the population (and the share of disabled versus elderly) did not change over time.

Under this exercise, average per capita spending for all Medicare beneficiaries would be lower in 1992 than the actual number, indicating that the aging of the population does slightly bias spending upward. The 1992 actual per capita amount was $3391, while our age-controlled simulation yielded a per capita average of $3324. Translating this into growth rates implies that spending each year is about 0.2 percent higher as a result of the changing demographics within the elderly population.

CONCLUSION

While we find little evidence to support the claims that the private sector is doing dramatically better than Medicare, this should not be interpreted as a claim that nothing can

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[18]Actually, this finding is consistent with other analysis suggesting that attributing the high costs of medicare to the very old or those at the end of life usually overstates that impact (Lubitz and Riley, 1993).

[19]We also conducted this exercise using 1992 age distributions as the control factor and the results are essentially the same.

or should be done to try to slow the rate of spending in the Medicare program. Indeed, high growth rates in this program create problems for federal government financing and for out-of-pocket burdens on older and disabled Americans who pay a share of these costs. Serious efforts will need to be made in the future to slow these growth rates. Medicare could and should do better; indeed even within its current structure a number of efforts could slow growth--particularly in the areas of home health, skilled nursing facility care and outpatient hospital services, for example. But such efforts will require us to face up to tough choices if health care spending is to be controlled.

Unfortunately, some of the debate on slowing Medicare's growth has suggested that by simply adopting principles developed in the private insurance market, Medicare's problems can easily be resolved. Discrepancies in growth in spending between Medicare and private insurance are used to support such claims.

Our findings indicate that growth rates in Medicare and private insurance are quite similar when carefully measured. Historically, Medicare stacks up very well with the private sector. And, even if private insurance does well in the next few years, no one knows very much about the sustainability of these low growth rates over time. In fact, it should not be surprising for Medicare and private insurance per capita rates to turn out to be very similar, since all health care spending shares technological change and improvement as a common major determinant of growth (Newhouse 1993). Reining in use of services will constitute a major challenge for both private insurance and Medicare in the future.

If the private insurance market, through the expansion of managed care, is truly successful in restraining growth, Medicare may be able to benefit from adopting some or all

of the techniques. However, the emerging forms of managed care (e.g. POS and PPO plans) have little experience in covering elderly and disabled populations. And as yet, techniques for determining the appropriate payments to make to plans that cover beneficiaries are not well developed. Careful consideration will be needed to determine how these plans control expenditures, how this affects patient outcomes, and whether these methods should be adopted by Medicare. For example, if managed care reduces spending by eliminating not only unnecessary services, but some necessary ones as well, it may be difficult for a public program to adopt such stringent controls (Newhouse, et al., 1982). As yet, however, there is little evidence to reassure us that such success has yet been established or will be painless in its implementation.

APPENDIX

Most of the analysis in this paper uses data from the National Health Expenditure accounts (Levit et al. 1994). These data are available on disk and allowed us to examine eight categories of spending (as shown in Tables B and C) by type of payer. These data are gathered in different ways, but there is an attempt to assure that these figures conceptually track the same components of spending and that they are national in scope. As a result these are the most consistent data available. Most of our analysis concentrated on Medicare and private insurance. The private insurance data include all types of private insurance: employer-based and privately purchased plans for younger families and medigap policies for the elderly and disabled. Our preference would have been to take medigap out of these numbers, but that was not possible.

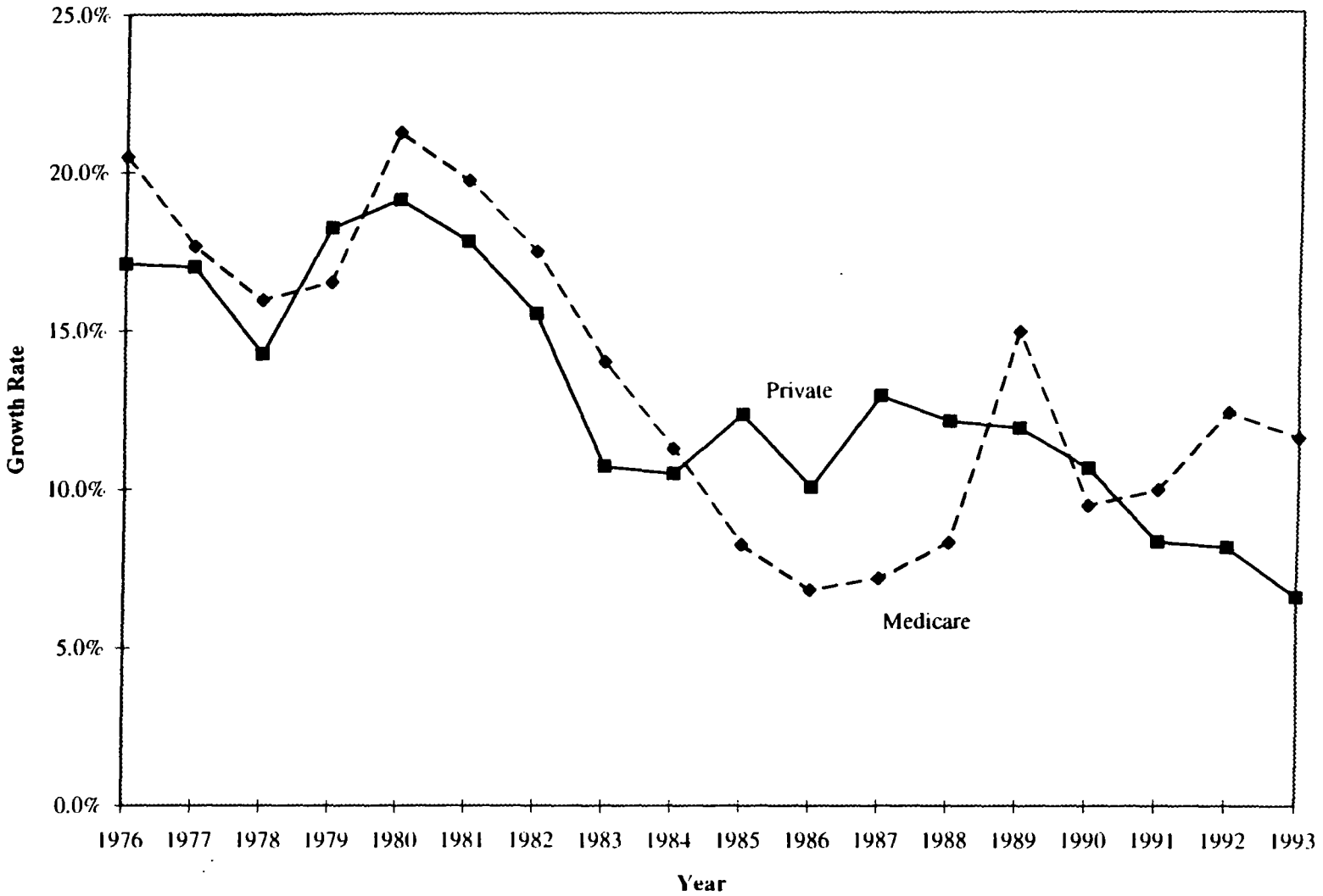
Growth rates for aggregate data were calculated by dividing nominal dollars in year one by year two. That growth rate is shown as year two's growth rate. For purposes of this analysis we used data back to 1975. By that time, the disabled population had been assimilated into Medicare and it was during that period that interest in containing costs began. Per capita dollar spending values were created using numbers supplied to us by the Office of the Actuary of the Health Care Financing Administration (HCFA). The private insurance numbers were adjusted to create an unduplicated count of the number of persons with some type of private health insurance. After calculating per capita spending numbers, we then estimate annual growth rates for each of the various spending categories.

We used two criteria for determining which categories to include in our comparative measure: the figure had to be positive for both Medicare and private insurance (which ruled out drugs and dental services as shown in Table 1), and the categories needed to primarily capture acute care benefits. This second criterion is somewhat more controversial since it omits nursing home and home health services, both of which are growing rapidly under Medicare at present. Moreover, in theory, these services might have grown because of the rapid changes in inpatient hospital lengths of stay after the introduction of the hospital prospective system under Medicare in 1984. But between 1985 and 1989, home health spending under Medicare declined in per capita terms and skilled nursing facility services grew quite slowly(see Appendix Table C). The rates of growth for both picked up at the end of the 1980s and continued into the 1990s. From other analysis in this area, we find that much of the recent growth in these programs is in a shift toward long term care, particularly in the case of home health services (Kenney and Moon 1995). Much of the growth in home health services, for example, is for home health aides rather than for skilled services.

Our analysis of whether the aging of the Medicare population over time contributed to its rate of growth used HCFA data on per capita spending over four different years and used two different index calculations. Detailed results are not presented here since we found that the increasing share of Medicare beneficiaries over the age of 85 and under the age of 65 (the disabled) did not add substantially to growth over time. This is consistent with findings on other studies about expenditures at the end of life (Lubitz and Riley 1993).

Appendix Chart A

Aggregate Growth in Medicare and Private Insurance Spending 1976-1993



Source: National Health Expenditure Data,
Health Care Financing Administration

Appendix Table A

Comparison of Growth Rates for Alternative Measures of Health Care Spending

	Aggregate Total Personal Health Expenditures		Per Capita Total Personal Health Expenditures		Per Capita Subtotal of Consistently Covered Services	
Dates	**Medicare**	**Private**	**Medicare**	**Private**	**Medicare**	**Private**
1976	20.5%	17.1%	17.2%	15.8%	17.0%	14.4%
1977	17.7%	17.0%	14.1%	12.3%	14.2%	11.9%
1978	15.9%	14.2%	13.0%	14.5%	13.1%	13.1%
1979	16.5%	18.2%	13.6%	17.0%	13.6%	16.5%
1980	21.3%	19.1%	18.7%	17.9%	18.9%	17.3%
1981	19.7%	17.8%	17.7%	16.4%	17.6%	15.7%
1982	17.5%	15.5%	15.5%	14.1%	15.3%	13.1%
1983	14.0%	10.7%	12.1%	10.1%	12.0%	9.4%
1984	11.3%	10.5%	9.4%	10.0%	9.3%	8.9%
1985	8.3%	12.3%	6.2%	11.9%	6.4%	11.0%
1986	6.8%	10.0%	4.5%	8.1%	4.8%	7.6%
1987	7.2%	12.9%	5.2%	11.7%	5.4%	11.1%
1988	8.3%	12.1%	6.3%	10.9%	6.0%	11.4%
1989	14.9%	11.9%	12.9%	10.7%	9.9%	10.7%
1990	9.5%	10.6%	7.5%	9.7%	8.1%	9.1%
1991	9.9%	8.3%	7.7%	9.2%	6.7%	9.0%
1992	12.4%	8.2%	10.2%	8.6%	8.1%	8.4%
1993	11.6%	6.6%	9.4%	7.2%	7.4%	7.1%

Source: National Health Expenditure Data,
Health Care Financing Administration

Appendix Table B

Per Capita Growth Rates for Medicare and Private Insurance for Consistently Covered Services

	Hospital Services		Physician Services		Other Professional Services		Vision and DME		Subtotal of Consistently Covered Services		Total Personal Health Expenditures	
Dates	**Medicare**	**Private**	**Medicare**	**Private**	**Medicare**	**Private**	**Medicare**	**Private**	**Medicare**	**Private**	**Medicare**	**Private**
1976	17.7%	14.9%	13.6%	13.0%	32.2%	27.6%	18.6%	4.8%	17.0%	14.4%	17.2%	15.8%
1977	13.1%	11.7%	17.1%	11.6%	26.2%	25.0%	25.4%	13.9%	14.2%	11.9%	14.1%	12.3%
1978	12.3%	14.6%	14.4%	9.2%	22.2%	22.7%	30.1%	20.4%	13.1%	13.1%	13.0%	14.5%
1979	13.2%	16.0%	14.7%	16.8%	11.3%	23.0%	21.2%	27.0%	13.6%	16.5%	13.6%	17.0%
1980	18.8%	17.1%	19.1%	17.4%	12.7%	16.4%	29.5%	23.6%	18.9%	17.3%	18.7%	17.9%
1981	17.8%	14.0%	16.4%	18.1%	13.4%	41.8%	31.0%	6.4%	17.6%	15.7%	17.7%	16.4%
1982	14.4%	13.5%	17.2%	11.6%	24.3%	21.5%	26.3%	10.0%	15.3%	13.1%	15.5%	14.1%
1983	10.2%	7.1%	16.0%	13.9%	20.9%	16.8%	28.8%	5.3%	12.0%	9.4%	12.1%	10.1%
1984	9.1%	4.3%	9.4%	15.9%	13.9%	36.1%	14.1%	14.8%	9.3%	8.9%	9.4%	10.0%
1985	5.0%	5.2%	9.7%	19.3%	13.4%	33.8%	11.9%	14.3%	6.4%	11.0%	6.2%	11.9%
1986	1.8%	4.9%	11.9%	10.7%	17.9%	20.4%	11.6%	-3.2%	4.8%	7.6%	4.5%	8.1%
1987	2.1%	9.6%	13.2%	12.1%	12.4%	22.5%	12.4%	10.6%	5.4%	11.1%	5.2%	11.7%
1988	4.5%	9.1%	9.3%	12.1%	8.1%	32.0%	9.6%	6.9%	6.0%	11.4%	6.3%	10.9%
1989	9.5%	9.6%	10.2%	11.0%	18.4%	19.4%	10.7%	4.6%	9.9%	10.7%	12.9%	10.7%
1990	7.2%	7.6%	8.0%	10.8%	25.6%	12.1%	15.8%	0.2%	8.1%	9.1%	7.5%	9.7%
1991	7.1%	8.3%	2.7%	8.9%	23.0%	15.8%	20.5%	-0.9%	6.7%	9.0%	7.7%	9.2%
1992	10.2%	6.5%	1.1%	10.3%	20.9%	13.0%	10.4%	-1.0%	8.1%	8.4%	10.2%	8.6%
1993	8.0%	8.5%	5.5%	6.2%	10.0%	2.7%	8.2%	-2.4%	7.4%	7.1%	9.4%	7.2%

Source: National Health Expenditure Data,
Health Care Financing Administration

Appendix Table C

Per Capita Growth Rates for Medicare and Private Insurance for Other Spending Categories

	Nursing Homes		Home Health		Drugs and other Nondurables		Dental Services		Subtotal of Other Spending Categories	
Dates	**Medicare**	**Private**	**Medicare**	**Private**	**Medicare**	**Private**	**Medicare**	**Private**	**Medicare**	**Private**
1976	14.2%	17.6%	40.8%	70.8%	0.0%	13.1%	0.0%	56.5%	24.8%	34.5%
1977	-1.0%	15.6%	25.2%	38.9%	0.0%	6.6%	0.0%	23.2%	10.7%	16.7%
1978	-1.7%	31.4%	20.2%	56.7%	0.0%	25.1%	0.0%	31.6%	9.4%	30.0%
1979	2.7%	26.7%	21.0%	21.4%	0.0%	22.2%	0.0%	21.4%	12.9%	21.8%
1980	7.9%	22.8%	16.2%	20.5%	0.0%	24.4%	0.0%	22.9%	12.8%	23.3%
1981	8.1%	32.7%	27.8%	13.0%	0.0%	16.1%	0.0%	25.4%	20.2%	21.8%
1982	6.8%	37.0%	26.4%	22.9%	0.0%	28.2%	0.0%	17.1%	19.6%	21.8%
1983	4.3%	29.7%	20.7%	19.6%	0.0%	17.1%	0.0%	14.1%	15.6%	16.0%
1984	5.7%	25.3%	15.7%	18.1%	0.0%	20.7%	0.0%	15.3%	12.9%	17.8%
1985	1.4%	25.8%	-0.6%	16.8%	0.0%	24.3%	0.0%	13.7%	0.0%	18.4%
1986	-2.4%	21.8%	-6.5%	23.3%	0.0%	11.2%	0.0%	9.5%	-5.4%	11.3%
1987	6.0%	20.2%	-5.8%	13.8%	0.0%	13.4%	0.0%	16.6%	-2.6%	15.5%
1988	47.6%	9.2%	6.3%	6.9%	0.0%	9.3%	0.0%	7.1%	18.6%	8.1%
1989	261.2%	3.2%	22.4%	30.8%	0.0%	16.4%	0.0%	6.2%	111.1%	10.9%
1990	-31.3%	16.0%	49.5%	29.7%	0.0%	21.0%	0.0%	5.0%	-1.8%	13.3%
1991	16.1%	5.2%	38.5%	5.5%	0.0%	17.7%	0.0%	4.3%	28.5%	10.3%
1992	55.2%	2.7%	36.3%	25.1%	0.0%	8.7%	0.0%	9.4%	43.9%	9.5%
1993	32.7%	-5.4%	33.9%	18.7%	0.0%	8.0%	0.0%	6.4%	33.4%	7.3%

Source: National Health Expenditure Data,
Health Care Financing Administration

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HOW DO MEDICARE PHYSICIAN FEES COMPARE TO PRIVATE PAYERS?

Mark E. Miller
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