

THE FUTURE OF MEDICARE AS AN ENTITLEMENT PROGRAM

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Based on her presentation at the University of Illinois College of Law's Elder Law Lecture, Dr. Marilyn Moon addresses the concern that Medicare as an "entitlement" program is growing without constraints and is unsustainable in light of the upcoming baby boom surge. In her essay, Dr. Moon examines the entitlement aspects of Medicare and the effect of the Medicare Prescription Drug Improvement and Modernization Act of 2003. Dr. Moon theorizes that the recent legislative changes may undermine some of Medicare's key strengths and entitlement status over time, creating an imbalance of coverage between the lower and higher income beneficiaries and discouraging people with health care problems from joining particular plans. As a result, Dr. Moon argues that the risks that impact the entitlement status of Medicare must be carefully weighed against the savings desired. Dr. Moon concludes that healthy debate must focus on the logical extension of the Medicare Prescription Drug Improvement and Modernization Act of 2003 and Medicare's entitlement and social insurance status in the future.

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The Medicare program represents one of the most popular of all federal programs, serving over 41 million people, many of whom would otherwise be unable to purchase health insurance.¹ Like Social Security, Medicare is a social insurance program, offering guaranteed benefits to those eligible by virtue of their Social Security eligibility. But, because the majority of beneficiaries are older Americans and the baby boom surge in enrollment is less than a decade away, the Medicare program is under scrutiny for both its current level of spending and the promise of high rates of future spending growth. Indeed, many policy makers have referred to Medicare as “unsustainable,” growing without constraints because it is an “entitlement” program.²

Much of the controversy on Medicare’s future centers on Medicare’s “entitlement” status because this means that Medicare spending grows automatically as the number of persons eligible for benefits and the costs of those benefits rise over time.³ Such flexibility in spending is required for this social insurance program to guarantee coverage to all who are eligible. In practice, the terms “entitlement” and “social insurance” are treated relatively interchangeably by policy makers.

Examining what should be done about Medicare’s future is both a controversial issue and one that will likely be part of the political debate for some time to come. Nearly all Americans have a stake in this program. Medicare serves almost everyone age sixty-five and above and over 6 million persons with disabilities.⁴ Further, the program relieves younger families of financial burdens they likely would otherwise bear in aiding their parents and grandparents. On the financing side, nearly all adults pay either or both the payroll and income taxes that support Medicare. Any increase in protection under Medicare also represents an increased burden on taxpayers.

Consequently, the search for a means to slow program growth has been a high congressional priority for more than two decades. But only recently have legislative changes begun to attack the basic enti-

1. 2003 BDS. OF TR., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TRUST FUNDS ANN. REP. 24 [hereinafter 2003 ANN. REP.].

2. See, e.g., Press Release, Sen. Don Nickles, Floor Statement on Medicare (Nov. 23, 2003), http://nickles.senate.gov/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=291&Month=11&Year=2003.

3. See Neil Howe & Richard Jackson, *It's Official: \$24 Trillion in Unfunded Liabilities*, FACING FACTS ALERT (Concord Coalition, Arlington, Va.), June 4, 2003, http://concordcoalition.org/facing_facts/alert_v9_n3.html.

4. 2003 ANN. REP., *supra* note 1, at 119.

tlement nature of the program, leading to changes that may undermine some of Medicare's key strengths over time.⁵

I. Social Insurance and Entitlements as Positive Qualities

Three crucial principles are integrally related to Medicare's role as both a social insurance and an entitlement program:

- The universal nature of the program and its consequent redistributive function.
- The pooling of risks that Medicare has achieved to share the burdens across sick and healthy.
- The role of government in protecting the rights of beneficiaries.

Although there are clearly other goals for and contributions of Medicare, these three are part of its essential core that has helped to maintain the popularity of this program for the past thirty-eight years. But a key question is whether the changes contained in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)⁶ will undermine the entitlement and social insurance benefits that have been so important to Medicare over time.

A. Universality and Redistribution

One of Medicare's great strengths has been providing much improved access to health care. Before Medicare's passage, many elderly persons could not afford insurance, and others who could not obtain it were denied coverage as poor risks.⁷ That changed in 1966 and it had a profound impact on the lives of millions of seniors. The desegregation of many hospitals occurred under Medicare's watch.⁸ And although there is substantial variation in the ability of beneficiaries to supplement Medicare's basic benefits, basic care is available to all who

5. JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE 174-89* (2003).

6. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

7. NAT'L ACADEMY OF SOC. INS., *MEDICARE AND THE AMERICAN SOCIAL CONTRACT 1* (Feb. 1999), http://www.nasi.org/usr_doc/med_report_soc_contract.pdf.

8. See Rosemary A. Stevens, *Health Care in the Early 1960s*, *HEALTH CARE FINANCING REV.*, Winter 1996, at 11, 11-12.

carry a Medicare card. Hospitals, physicians, and other providers largely accept the card without question.⁹

Once on Medicare, enrollees no longer have to fear that illness or high medical expenses could lead to the loss of coverage—a problem that still occurs too often in the private sector. This assurance is an extremely important benefit to many older Americans and persons with disabilities, a large share of whom have existing health conditions that make them poor risks in the eyes of private insurance.¹⁰ Developing a major health problem is not grounds for losing the Medicare card; in fact, in the case of the disabled, it is grounds for coverage.¹¹ This is vastly different than the philosophy of the private sector towards health coverage. Even though many private insurers are willing and able to care for Medicare patients, the easiest way to stay in business as an insurer is to seek out the healthy and avoid the sick.¹² And, in a market system, once risk selection becomes the norm, even insurers who would like to treat sicker patients are penalized by the market if they do so.¹³ This can clearly be seen in the poor performance of the individual health insurance market in meeting the needs of persons in their early sixties and recently in the Medicare+Choice program.¹⁴

Will reforms that lead to a greater reliance on the market still retain the emphasis on equal access to care and plans? For example, differential premiums could undermine some of the redistributive nature of the program that assures even low-income beneficiaries access to high quality care and responsive providers. Will risk selection result in unduly high costs for plans that attract a sicker population?

Further, the government is able to collect contributions over time that vary by individuals' wages and income while providing a stan-

9. See MEDICARE PAYMENT ASSESSMENT COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 153 (Mar. 2003), http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf [hereinafter MED-PAC REPORT 2003].

10. See MARILYN MOON & MATTHEW STOREYGARD, ONE-THIRD AT RISK: THE SPECIAL CIRCUMSTANCES OF MEDICARE BENEFICIARIES WITH HEALTH PROBLEMS (Sept. 2001), http://www.cmwf.org/programs/medfutur/moon_one-third_474.pdf.

11. *Medicare Reform: Hearings Before the Sen. Comm. on Fin.*, 106th Cong. 496 (1999) (prepared statement of Marilyn Moon, Senior Fellow, Urban Institute).

12. Marilyn Moon, *Building on Medicare's Strengths*, ISSUES IN SCI. & TECH. ONLINE, Winter 1999, at <http://www.issues.org/issues/16.2.htm>.

13. See MARILYN MOON & JANEMARIE MULVEY, ENTITLEMENTS AND THE ELDERLY: PROTECTING PROMISES, REORGANIZING REALITIES 87-88 (1996).

14. See generally Marsha Gold, *Medicare+Choice: An Interim Report Card*, HEALTH AFF., July-Aug. 2001, at 120.

standard benefit to all enrollees. In this way, the program is able to assure access to mainstream care for retirees at all levels of income. In fact, Medicare is a more progressive program than Social Security when both the contributions and benefits sides are taken into account.¹⁵ This is because the benefits are the same, while contributions are higher from persons with high incomes.¹⁶ In contrast, private insurers do not have mechanisms for such redistribution; adding that factor to private insurance may not work well.

B. The Pooling of Risks

One of Medicare's important features is the achievement of a pooling of risks among the healthy and sick covered by the program. Even among the oldest of beneficiaries, there is a broad continuum across individuals' needs for care.¹⁷ Although some of this distribution is totally unpredictable (because even people who have historically had few health problems can be stricken with catastrophic health expenses), a large portion of seniors and disabled persons have chronic problems known to be costly to treat.¹⁸ If these individuals can be identified and segregated, the costs of their care can expand beyond the ability of even well-off individuals to pay over time.

A major impetus for Medicare was the need to protect the most vulnerable. That is why the program focused exclusively on the old in 1965 and then added the disabled in 1972.¹⁹ About one in every three Medicare beneficiaries has severe mental or physical health problems.²⁰ In contrast, the healthy and relatively well-off (with incomes over \$32,000 per year for singles and \$40,000 per year for couples) make up less than ten percent of the Medicare population.²¹ Consequently, anything that puts the sickest at a greater risk relative to the healthy is out of sync with this basic tenet of Medicare. A key test of any reform should be whom it best serves.

If the advantages of one large risk pool (such as the traditional Medicare program) are eliminated, other means will have to be found to make sure that insurers cannot find ways to serve only the healthy

15. MOON & MULVEY, *supra* note 13, at 87–88.

16. *Id.*

17. MOON & STOREYGARD, *supra* note 10, at 5.

18. *Id.* at vii.

19. OBERLANDER, *supra* note 5, at 40–42.

20. MOON & STOREYGARD, *supra* note 10, at 2.

21. Marilyn Moon, 2002 *Current Population Survey* (2002) (on file with author).

population. Although this very difficult challenge has been studied extensively, as yet, no satisfactory risk adjustor has been developed.²² Alternatively, “what has been developed to a finer degree . . . are marketing tools and mechanisms to select good risks,” undermining the risk pooling advantages that Medicare has traditionally enjoyed.²³ High-quality plans that attract people with extensive health care needs are likely to be more expensive than plans that focus on serving the relatively healthy. If risk adjustors never become powerful enough to eliminate these distinctions and level the playing field, then those with health problems, who also disproportionately have lower incomes, would have to pay the highest prices under many reform schemes.

C. The Role of Government

Related to the two above principles is the role that government has played in protecting beneficiaries. In traditional Medicare, this has meant having rules that apply consistently to individuals and assuring that everyone in the program has access to care. The traditional program “has sometimes fallen short in terms of the variations that occur around the country in benefits, in part because of interpretation of coverage decisions but also because of differences in the practice of medicine.”²⁴ For example, rates of hospitalization, frequency of operations such as hysterectomies, and access to new tests and procedures vary by residence, race, and other characteristics.²⁵ And minorities, while getting better access to care through Medicare than elsewhere still exhibit troubling variations in treatments and services.²⁶ However, Medicare generally has to meet substantial standards and accountability that protect its beneficiaries.

A key aspect of meeting these promises has been the treatment of Medicare as an “entitlement.” Ironically, a term that began as a

22. JOSEPH P. NEWHOUSE ET AL., RISK ADJUSTMENT AND MEDICARE 1 (June 1999), http://www.cmwf.org/programs.medfutur/newhouse_riskadj_revised_232.pdf.

23. *Medicare Reform and Competition: Separating Fact from Fiction: Hearing Before the Sen. Special Comm. on Aging*, 108th Cong. 61 (2003) (statement of Marilyn Moon, Senior Fellow, Urban Institute).

24. *Id.* at 61–62.

25. Marilyn Moon & Cristina Boccuti, *Location, Location, Location: Geographic Spending Issues and Medicare Policy*, HEALTH POL’Y BRIEFS (Urban Inst., Wash., D.C.), June 2002, at 2–3, http://www.urban.org/UploadedPDF/310500_No2.pdf.

26. Marilyn Moon, *What Medicare Has Meant to Older Americans*, HEALTH CARE FINANCING REV., Winter 1996, at 49, 54–56.

specific type of federal budget category has often taken on a pejorative connotation. Until very recently, the term was mainly used in budget circles to refer to programs that make payments to any person, business, or unit of government that seeks the payments and that meets the eligibility established by law.²⁷ Congress controls entitlement programs indirectly by establishing rules for eligibility and benefits, rather than through the annual appropriations process. This budgetary characteristic leads to a program being categorized as an entitlement. The U.S. General Accounting Office has stated: "Authorization for entitlements constitute a binding obligation on the part of the Federal Government, and eligible recipients have legal recourse if the obligation is not fulfilled."²⁸

In the case of Medicare, legislative language on who is eligible and for what level of benefits determines spending each year. Why are entitlements exempted from the annual appropriations process? These programs were given special treatment in order to protect them from the annual debate on the budget. An entitlement program may thus be thought of as one established to be exempt from the vagaries of annual political wrangling. That is, Medicare is allowed to bypass the annual appropriations process in order to assure people that they will receive the benefits promised in the legislation. Under Medicare, spending each year also needs to be flexible to respond to health care needs. The open-ended nature of health insurance in both the public and private sectors is such that it is difficult to establish before the fact what spending will or ought to be. Benefits are defined in terms of access to necessary medical expenditures, and the need for such care can vary over time. Moreover, technological change and new approaches to treatment mean that appropriate care will change over time. As currently designed, defining the benefit as access to necessary care provides stability and predictability for enrollees. Otherwise, if benefits covered were raised or lowered each year, individuals would not be able to plan for their needs, particularly in retirement where the ability to adjust to higher costs of health care is limited.

27. CONG. BUDGET OFFICE, *THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2005 TO 2014* 152 (Jan. 2004), <ftp://ftp.cbo.gov/49xx/doc4985/01-26-BudgetOutlook-EntireReport.pdf>.

28. U.S. GEN. ACCOUNTING OFFICE, *A GLOSSARY OF TERMS USED IN FEDERAL BUDGET PROCESS AND RELATED ACCOUNTING, ECONOMIC AND TAX TERMS* 57 (1981), <http://161.203.16.4/pdf/115332.pdf>.

II. Criticisms of the Entitlement Nature of Medicare

The very characteristics described above concerning the strengths of the Medicare program are often used to criticize it. Why should Medicare be treated differently than other government spending? Shouldn't all spending at the federal level require a yearly review? Shouldn't all programs have to compete against each other on equal footing? Further, isn't it the case that entitlements by their nature lead to higher rates of spending than other programs?

Although Medicare was designed to change slowly, it has not been exempt from change. At any time, Congress can—and often does—change the operating rules of the program to achieve a different spending level. For example, nearly every year between 1981 and 1993, modifications in the Medicare program were part of budget reconciliation legislation aimed at reducing federal spending.²⁹ Then, after a hiatus from substantial change, major adjustments to Medicare were made in 1997—accounting for a large share of changes necessary to achieve a balanced federal budget just two years later.³⁰ And, in late 2003, the program underwent substantial modifications under MMA. A prescription drug benefit was enacted, as well as a number of changes that may have far-ranging consequences for the treatment of Medicare as an entitlement program.

Does the flexibility of an entitlement program necessarily lead to more rapid spending growth? Although entitlement programs are not subject to appropriations, there is nothing inherent in the category of entitlements itself which would necessarily lead to disproportionate growth in spending. That growth depends upon the eligibility and benefit definitions built into law. Rising health care costs for people of all ages and the increasing share of the population over the age of sixty-five are mainly responsible for Medicare's rapid growth.³¹

Thus, recognizing that the congressional intent of entitlement programs was that they would grow unencumbered by politics (although it is also likely that few legislators expected such rapid growth) and respond only to the eligibility requirements established

29. See generally MARILYN MOON, *MEDICARE NOW AND IN THE FUTURE* (2d ed. 1996).

30. OBERLANDER, *supra* note 5, at 183–87.

31. See *Medicare's Financial Crisis: Hearing Before the Joint Econ. Comm.*, 108th Cong. 105–06 (2003) (prepared statement of Marilyn Moon, Senior Fellow, Urban Institute).

for the program is important.³² It is also important to periodically evaluate whether such preferential treatment is still desired and whether the same level of commitment is appropriate. Thus, if this special budget treatment is deemed to be warranted, the growth of Medicare should be viewed as an *intended* consequence over time.

III. Major Changes to the Structure of Medicare Under the MMA

The MMA makes significant changes in the basic structure of Medicare. Several of these provisions may have important consequences on the entitlement nature of the program. Before considering those potential effects, however, it is useful to examine the premise of the following aspects of the legislation:

- The emphasis on private plans for both the provision of the drug benefit and as an alternative to the basic fee-for-service portion of Medicare;
- The creation of a new indicator of financing problems, which will be triggered when general revenue spending on Medicare reaches forty-five percent of the overall cost of the program; and
- New distinctions among enrollees based on income.

A. Emphasizing the Private Sector

The MMA adds a new Preferred Provider Organization (PPO) option, establishing Medicare Advantage to include these new PPOs and plans now operating under Medicare+Choice.³³ The MMA provides special subsidies to serve as incentives for Medicare Advantage and stand-alone drug plans to participate in the program. At the same time, privatization has been touted by its supporters as the means for achieving slower rates of growth in Medicare spending over time.

Opposition to relying on private plans for Medicare stems from evidence suggesting that these plans are unlikely to slow cost growth over time and from practical concerns about whether new features, such as stand-alone prescription drug plans, will work at all. To date, the evidence shows that privatization will achieve few, if any, savings

32. BOB BALL, *INSURING THE ESSENTIALS* 250–51 (Thomas N. Bethell ed., 2000).

33. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 201, Pub. L. No. 108-173, 117 Stat. 2066, 2176.

for Medicare.³⁴ Certainly, the claim that privatization is essential to holding down costs for Medicare's future is on shaky ground. Recent experience with Medicare+Choice plans suggests that beneficiaries are paying more and getting less value in return.³⁵ Moreover, over the last thirty years, Medicare growth has been below that of either private insurance overall or the Federal Employees Health Benefits Program.³⁶

One of the chief ways in which managed care was able to hold down costs as compared to private fee-for-service plans was by obtaining discounts from hospitals, doctors, and other care providers,³⁷ but few plans can do as well as Medicare in that regard. Further, administrative costs for Medicare are very low.³⁸ The only other avenue then is to truly manage care, reducing use of goods and services. Thus far, most private plans have not created new or innovative delivery systems that generate substantial savings over time while retaining consumer satisfaction. Rather, they have been able to succeed largely where they have attracted healthier than average enrollees and hence have implicitly been overpaid.³⁹

With private plans serving mainly healthier Medicare beneficiaries, they appear more efficient than they turn out to be once the effects of risk selection are taken into account.⁴⁰ Plans have usually offered additional benefits to enrollees as a result of the excess payments, but they have not saved money for the federal government.⁴¹ This satis-

34. U.S. GEN. ACCOUNTING OFFICE, *MEDICARE+CHOICE: PAYMENTS EXCEED COST OF FEE-FOR-SERVICE BENEFITS, ADDING BILLIONS TO SPENDING* (Aug. 2000), <http://www.gao.gov/archive/2000/he00161.pdf>.

35. See, e.g., Marsha Gold & Lori Achman, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase 10 Percent in 2003*, ISSUE BRIEF (Commonwealth Fund, New York, N.Y.), Aug. 2003, <http://www.cmf.org/programs/me.PDF>.

36. *What's Driving Health Care Costs and the Uninsured?*, *Hearing Before the Sen. Comm. on Health, Educ., Labor, & Pensions*, 108th Cong. (2004) (testimony of Karen Davis, President, Commonwealth Fund), at http://www.cmf.org/programs/quality/davis_senatehelpstestimony_714.pdf.

37. See OFFICE OF HEALTH CARE ACCESS, STATE OF CONN., *MANAGED CARE DISCOUNT RATES*, <http://www.ohca.state.ct.us/Publications/mcareratesweb.pdf> (Apr. 14, 2000).

38. 2003 ANN. REP., *supra* note 1, at 158.

39. MEDICARE PAYMENT ASSESSMENT COMM'N, *REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 211* (Mar. 2004), http://www.medpac.gov/publications/congressional_reports/Mar04_Entire_reportv3.pdf [hereinafter *MED PAC Report 2004*].

40. *Id.*

41. See *MEDPAC REPORT 2003*, *supra* note 9, at 195.

fies their own enrollees but does little to address Medicare's long run needs.

Under MMA, payments to private plans are likely to continue to exceed what it would cost to provide benefits through the traditional Medicare program. The Congressional Budget Office estimated that between 2005 and 2013, private plans would add \$14.2 billion to the costs of the legislation in bonus payments.⁴² The subsidies would be direct, through explicitly higher payments to plans, and indirect, because the basic payment levels are also being adjusted in ways that will further hike the payments. Presumably, these higher payments are intended to jumpstart a competitive system.

If plans must be paid more than it costs to serve beneficiaries in traditional Medicare, how is it possible to assume that they will save money for the program over time? What would happen to change that outlook for the future? In the case of PPOs, savings arise from enrolling efficient providers in their networks who are less likely to order tests and procedures. In addition, savings also come from paying very low amounts on services used outside the network, both by having higher co-payments and by setting the amounts they pay for such services at a very low level.⁴³ This creates a conundrum for Medicare. The legislation limits how much beneficiaries must pay for using out-of-network services.⁴⁴ However, this constraint effectively eliminates a major tool that PPOs rely upon for cost savings. There will likely be pressure over time to give PPOs more flexibility in paying for out-of-network services in order to keep them in the program.

Further, the emphasis on consumer choice can undermine plans' abilities to generate price competition and thus, savings. If plans can vary in the benefits they offer, they may use marketing and benefit structure, rather than lower premiums, to attract customers. For this reason, some proponents of competition emphasize that cost savings also will depend on the extent to which the emphasis is on price, and

42. Letter from Douglas Holtz-Eakin, Director, Congressional Budget Office, to Congressman Bill M. Thomas, Chairman, Committee on Ways and Means, U.S. House of Representatives (Nov. 14, 2003), <http://www.cbo.gov/showdoc.cfm?index=4807&sequence=0>.

43. See generally CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) DEMONSTRATION FACT SHEET, <http://www.cms.hhs.gov/researchers/demos/PPOFactFinal0304.pdf> (last visited Apr. 20, 2004).

44. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 211, Pub. L. No. 108-173, 117 Stat. 2066, 2176.

hence, the need to ensure that plans vary little in terms of what they offer to consumers.⁴⁵ Ironically, one of the selling points for relying on private plans—that people can get precisely the benefits they want rather than being put into a “one-size-fits-all” structure⁴⁶—may be at odds with holding down the costs of health coverage.

Lower priced plans, even of questionable quality, may be promoted, while putting traditional Medicare or higher priced plans at a disadvantage. Ultimately, if no savings are achieved, policy makers may look to even stronger competitive approaches. Although that is the focus of the 2010 “demonstration,”⁴⁷ higher rates of growth than now anticipated may speed up that process and encourage supporters to skip the experimental period altogether.

Alternatively, there may be efforts to move to a full voucher approach for Medicare. Essentially, Medicare beneficiaries would be given a fixed amount to help pay for the costs of the health plan of their choice, presumably in a market much like the one that individuals under age sixty-five now face if they do not have employer-based coverage. Thus, the program would assure a defined contribution for services instead of a defined set of benefits.⁴⁸ If the contribution were not high enough to purchase a good insurance policy, beneficiaries would have to pay more. Second, the federal government would no longer act in the role of an insurer; traditional fee-for-service would be disbanded and all beneficiaries would be required to choose among private plans. Although there are a number of different potential approaches, the goal that unites most of these plans is to reduce substantially the government’s control over health care.

Supporters of this approach believe that vouchers would make beneficiaries and insurers more conscious of costs.⁴⁹ The advantages, from the perspective of voucher plan supporters, are the resulting in-

45. See Robert Reischauer, Presentation at the Alliance for Health Reform and NASI, Changing Medicare: Proposals to Strengthen the Program (Apr. 22, 2003) (transcript available at http://www.kaisernetwork.org/health_cast/uploaded_files/042203_alliance_present.pdf).

46. See generally Press Release, The White House, Strengthening Medicare: A Framework to Modernize and Improve Medicare (Mar. 4, 2003), at <http://www.whitehouse.gov/news/releases/2003/03/print/20030304-1.html>.

47. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

48. Moon, *supra* note 29, at 166–69.

49. Randall R. Bovbjerg, *Vouchers for Medicare: The Impossible Dream?*, in *LESSONS FROM THE FIRST TWENTY YEARS OF MEDICARE* 25, 32–33 (Mark V. Pauly & William L. Kissick eds., 1998).

creased choice and competition that the market can foster, presumably resulting in higher quality benefits at lower costs for beneficiaries.⁵⁰ For example, individuals might be able to opt for larger deductibles or co-insurance in return for coverage of other services such as drugs or long-term care. Because many Medicare enrollees now choose to supplement Medicare with private insurance, this approach would allow beneficiaries to combine the voucher with their own funds and buy one comprehensive plan. No longer would enrollees have to worry about coordinating coverage between Medicare and their private supplemental plan. Moreover, persons with employer-provided supplemental coverage could remain in the health care plans they had as employees. To the government, this option would have the appeal of enabling a predictable rate of growth in the program.⁵¹

B. A New Measure of Financial Health

The MMA also creates a new measure of financial health of the Medicare program. This idea was also considered in 1999 by some members of the Bipartisan Medicare Commission who expressed concern that the general revenue contribution requirement under Part B created an open-ended commitment to Medicare.⁵² Under current law, general revenues rise as needed to pay for Part B spending, supplementing beneficiary premiums.⁵³ However, the Bipartisan Medicare Commission co-chairs argued that the increased burden that Part B places on society is masked by the current approach.⁵⁴ Therefore, they sought to establish a limit on general revenue contributions, analogous to the payroll tax contribution rate that is set by law. The Commission therefore proposed, as part of its recommendations,⁵⁵ that when general revenues reached forty percent of the costs of all

50. *Id.*

51. Greg Scandlen, *Defined Contribution Health Insurance*, POL'Y BACKGROUND (Nat'l Ctr. for Policy Analysis, Wash., D.C.), Oct. 26, 2000, <http://www.ncpa.org/bg/bg154/bg154.html#a>.

52. MARILYN MOON & MATT STOREYGARD, SOLVENCY OR AFFORDABILITY? WAYS TO MEASURE MEDICARE'S FINANCIAL HEALTH 8-9 (Mar. 2002), http://www.urban.org/UploadedPDF/1000248_solveny.pdf.

53. 2003 ANN. REP., *supra* note 1, at 2.

54. MOON & STOREYGARD, *supra* note 52, at 8.

55. A majority of commission members agreed to a set of recommendations, but the number fell short of the level established in legislation to formally transmit their recommendations to the President and Congress. Thus, while there was no formal final report, this solvency measure was broadly discussed.

Medicare benefits, the contribution would be frozen at that share unless Congress voted to increase it.

The MMA adopted a similar new measure of solvency that would be triggered when the general revenue contributions reach forty-five percent of total Medicare spending.⁵⁶ The law requires that the President and Congress consider what should be done to resolve the “problem.” This will effectively create a crisis where none exists, although the legislation does not require that any further legislation—for example, reducing benefits—take place. Nonetheless, it would not take much to create rules for such reductions; again, part of the issue is whether this legislation represents a first step toward eliminating the entitlement nature of the program. The final legislation softened the potential for such action, but it is likely to arise again for consideration in the future.

C. Creating Distinctions Among Beneficiaries by Level of Income

The MMA offers two sets of changes that vary the value of the program to beneficiaries at different levels of income. The first offers expanded benefits to those with low incomes and assets by enriching the prescription drug benefit.⁵⁷ The second creates a higher Part B premium starting with individuals whose annual incomes exceed \$80,000 and couples with incomes above \$160,000.⁵⁸ Replacing a much more controversial proposal to income-relate the benefit, this requirement keeps the income test on the revenue side—an important improvement. The Congressional Budget Office estimated that when this provision begins in 2007, it will affect only three percent of beneficiaries.⁵⁹ The share of beneficiaries subject to the income-related premium is expected to rise to six percent by 2013.⁶⁰

The payroll taxes that make up about half of Medicare’s financing are charged on all wages, no matter how high. As a result, individuals with very high incomes already contribute far more than it costs to serve them. Because the drug benefit is paid out of general

56. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 801, Pub. L. No. 108-173, 117 Stat. 2066, 2358.

57. *Id.* § 101, pt. D, subpt. 2, § 1860D-14, 117 Stat. at 2106.

58. *Id.* § 811(a)(i)(2), 117 Stat. at 2364–65.

59. Letter from Douglas Holtz-Eakin, Director, Congressional Budget Office, to Senator Don Nickles, Chairman, Committee on the Budget, U.S. Senate, tbl. 2 (Nov. 20, 2003), <http://www.cbo.gov/showdoc.cfm?index=4814&sequence=0>.

60. *Id.*

revenues, persons with substantial incomes who become Medicare beneficiaries will continue to contribute even after retirement. This new requirement thus builds on an existing financing system that asks higher income beneficiaries to pay more. Nonetheless, the requirement remains a controversial piece to many supporters of social insurance who see this as a first step towards breaking down the universality of the benefit.

The issue of greatest concern, however, is whether the resources that will be obtained through this mechanism will be substantial enough to justify the considerable new administrative costs and reporting requirements that will be engendered. The Social Security Administration will be required to obtain data from the Internal Revenue Service that can be used to establish what premium to charge for each Medicare beneficiary.

IV. Risks to Medicare's Entitlement Status from the MMA

Many of the changes in Medicare enacted by the MMA will have potential impacts on the entitlement and social insurance aspects of the program. These need to be weighed against the savings and other impacts that supporters hope will result from the emphasis on the private sector.

A. The Subsidies for Private Plans

The subsidies that will increase payments for private plans contained in the new legislation will create an uneven playing field, penalizing those beneficiaries who choose to remain in traditional Medicare. That is, these higher payments will allow Medicare Advantage insurers to offer improved benefits and perhaps higher payments to doctors, hospitals, and other providers of care—not because of greater efficiency, but because of favorable treatment by the government. Traditional Medicare will be left with an inadequate benefit package. Because individuals who are unwilling to take a chance on a new insurance option, and thus stay in traditional Medicare, tend to be sicker and older than average,⁶¹ this approach favors the healthy over the sick. This approach to favoring private plans violates the universality

61. MOON & STOREYGARD, *supra* note 10, at 6.

goal for the program and does so in a manner counter to where any favorable treatment ought to be directed.

B. The Creation of Multiple Benefit Options

Another consequence of offering “choice” to beneficiaries is the resulting imbalance in coverage that may result—again likely leaning in just the wrong direction. That is, plans that offer richer benefit packages and fewer controls on use of services will tend to be more expensive. If beneficiaries must pay substantially more to enroll in those plans, lower income individuals may end up in the less desirable plans. If the government contribution is sufficient to guarantee access to high quality plans, this is less of an issue. The easiest way to hold down costs over time will be to simply put a lid on how much the government will pay for each beneficiary over time. Medicare, which now gives most beneficiaries access to mainstream care, could become a two-class system.

C. Risk Selection Issues

Until or unless risk adjustors can be developed that do a much better job of encouraging private plans to want to enroll beneficiaries who are high cost users of medical services, the more choice and differentiation in the market, the greater the possibility for and likelihood of risk selection. The simplest way for private plans to make money at present is to serve a healthier than average population. Devising ways to attract those patients and discourage people with health care problems from joining particular plans is not difficult.

D. Vouchers

Over time, the risks of higher costs of health care are borne by the beneficiary and not the government; the government’s contribution presumably would be tied to a formula that may be unassociated with actual care costs. For example, a voucher could be set to grow at the rate of growth of the economy, even if health care costs are rising faster (as is often the case). In fact, the purpose of a voucher approach is to make the government’s share a more predictable, stable amount, placing the beneficiary at risk for rising costs.

Further, a voucher system would likely diminish Medicare’s social insurance role of pooling and redistributing the risks associated

with poor health in old age. Traditional Medicare places a large group of both the sickest and the healthiest beneficiaries under a large umbrella. This accomplishes two things. First, the larger the group, the lower the individual cost of insurance because risks are shared evenly. Second, benefits are redistributed between beneficiaries. The sickest beneficiaries with the most needs receive more benefits (or services) than do healthier beneficiaries. Vouchers can only accomplish these goals if there is an effective (and likely complicated) system for adjusting the voucher payments across individuals for differences in health status and risk. Thus far, such adjusters are crude and still being refined.⁶²

On balance, vouchers offer less in the way of guarantees for continued protection under Medicare. Vouchers are most appealing as a way to substantially cut the federal government's contributions to the plan indirectly through erosion of the comprehensiveness of coverage that the private sector offers rather than as stated policy. The risks under such a plan would be borne by beneficiaries.

The changes in the private option portion of Medicare do not go this far in making changes. Even the 2010 premium support experiment represents only a partial voucher approach. Nonetheless, some supporters and detractors believe this legislation is the first step toward transforming Medicare into a voucher program.

E. An Artificial Measure of Financial Health

The basic problem with establishing a share of general revenue spending as an indicator of a problem with the financial health of Medicare is that there is no basis for assuming that when general revenues reach that amount, a problem actually exists. First, consider why general revenue shares change. Medicare is largely funded by three sources: payroll taxes for Part A, Hospital Insurance, and general revenues (mainly income taxes) and beneficiary premiums for Part B, Supplemental Medical Insurance.⁶³ And, over time, Medicare spending has shifted out of inpatient hospitals and into outpatient settings and physician offices (which are covered by Part B).⁶⁴ As a result, general revenue funding has naturally risen over time in re-

62. NEWHOUSE ET AL., *supra* note 22.

63. 2003 ANN. REP., *supra* note 1, at 2-3.

64. MEDPAC REPORT 2003, *supra* note 9, at 5 fig. 1-1.

sponse to changes in medical practice. Thus, one source of the “problem” is essentially improvement in medical treatments.

Further, the general revenue share will rise over time as prescription drugs are added to the Medicare program. This can have the same effect as the shifting in practice patterns that has already occurred. Consider, for example, improvements that would result in drug therapy replacing surgery for several key health care problems. This “good news” could very well trigger a “crisis” in Medicare.

Moreover, such a measure implicitly establishes a preference for payroll tax financing as compared to income taxes—which make up the bulk of general revenues. Income taxes are more progressive and effectively cause higher income Medicare beneficiaries to pay more for their own care and payroll taxes are criticized as placing too great a burden on workers. Thus, good policy may dictate an increase in general revenue contributions to Medicare as a share of total spending, rather than trying to minimize it.

Ironically, if the emphasis on the private sector is unsuccessful in holding down cost growth—particularly for prescription drugs—the forty-five percent trigger will be met sooner rather than later. Medicare as a government program will be penalized for the failure of the private sector.

Finally, if this rule is used to justify capping or limiting benefits, it also becomes a means for undermining the social insurance and entitlement aspects of the Medicare program, all without a direct discussion of that very important policy issue. Financing the program for the future is too important an issue to be relegated to a “formula” dictating change.

F. Differentiating Benefits and Premiums by Income

Many supporters of social insurance have been very reluctant to see Medicare benefits differentiated by income, even if that means an improvement for those with few resources. This issue reflects the dilemma of choosing between what may be a good policy goal of helping those who find Medicare insufficient because of their own limited resources and the purest treatment of Medicare as social insurance.

At the other end of the income scale, many social insurance supporters fear that reducing the value of the program to those at higher income levels can undermine support. While a higher premium is technically different than unlevel benefits, it may well set a precedent

for further changes in the future. The practical concerns are also that the level of savings to the federal government will be relatively small until or unless the income limits (where the premium would begin to rise) are lowered substantially.

V. Conclusion

Most policy analysts believe that the changes made in the MMA are not the last that will need to occur in order to position Medicare for the future. The challenges of absorbing the baby boom into this program will be very great indeed.

Some of the concerns about the new changes enacted in Medicare stem more from what is perceived as the logical extension of the legislation rather than simply what has been recently put into law. Particularly if the enacted changes do not result in savings—as has been argued above to be a likely outcome—there may be a move to push further to reduce Medicare's entitlement and social insurance nature to slow the growth in spending more directly.

To the extent then that the MMA is a reflection of the direction of future policy changes, the social insurance and entitlement nature of Medicare will likely be challenged. A direct discussion of the issue is needed rather than allowing such fundamental changes in the program to occur without a healthy debate.