

1 Medicare Reform: The Stakes

Now in its fifth decade, Medicare provides health coverage to virtually all of the nation's elderly and a large share of people with disabilities, a population of some 44 million. The program has brought large benefits.¹ With dramatically improved access to health care, its beneficiaries have enjoyed longer, healthier lives.² It contributed to the desegregation of southern hospitals. And it is one of the most popular government programs, rivaling Social Security.

Despite Medicare's achievements and popularity, the program has always been controversial. In the bitter partisan dispute preceding its enactment, Democrats supported mandatory, payroll-tax-financed hospital care while Republicans sought voluntary, premium-, and tax-financed coverage of doctors' services. Physicians opposed both ideas, fearing government intrusion into medical practice. To appease them, the final plan required the government to pay all reasonable hospital costs and customary physician fees. That policy mollified providers but fueled rapid increases in hospital spending and doctors' fees. Soon, program outlays far outpaced original projections, and

Medicare was blamed for causing health care inflation. So, starting in the early 1980s, Congress required Medicare to pay health care providers in new ways designed to hold down spending. In the 1990s Congress enacted additional major payment cutbacks, but angry protests from aggrieved hospital and private plan administrators, among others, forced it to reverse many of these cuts. More recent concerns have focused on physician fees, rising expenditures, and overpayments to managed care plans.

Some of the debate also focuses on benefit limits imposed to hold down projected costs. To circumvent these limits, most Medicare enrollees have bought supplemental insurance to cover deductibles, cost sharing, and such excluded services as outpatient prescription drugs and long-term care. In 1988 Congress moved to fill the prescription drug gap. However, the law was so unpopular with beneficiaries that Congress repealed it little more than a year after enactment. Not until 2003 did Congress succeed in adding this service, long a feature of private health insurance plans. That bill also aroused intense controversy because of its design, administration, and manner of passage. It will be a source of debate for years to come.

Another looming issue is whether and how to change Medicare to deal with population aging and the proliferation of beneficial but costly interventions. These trends guarantee that Medicare spending will far outpace the growth of federal revenues and thereby increase the burden for those who pay for most of the program's costs—namely, taxpayers. Beneficiaries will face mounting challenges too, for they shoulder roughly one-fifth of the cost of the care they use. To complicate matters, the quality of services provided to all Americans, including Medicare beneficiaries, is deficient in important respects: as is well documented, errors are too common, and recommended care is frequently not rendered.³

Rising costs, limited access, and deficient quality are not the only problems. Considerable confusion arises in debates about health care policy in general, and Medicare in particular, because they combine issues from economics, politics, psychology, and medical science. Moreover, the stakes for all parties—patients, providers, insurers, and taxpayers—are high. The outcome will affect millions of people and involve trillions of dollars. To aid in understanding Medicare's complexities and assessing major policy proposals, this book offers a program "primer," describing its history, principal goals, operation, and future challenges.

Born in Turmoil

Medicare and Medicaid became law on the afternoon of July 31, 1965, at a signing ceremony in Independence, Missouri. President Lyndon B. Johnson had decided a few days before to move the event from Washington to Independence, the site of the library of former president Harry S. Truman. Johnson wanted to honor Truman for trying to win passage of national health insurance. Although that effort was entirely without success, it started the lengthy political process that led to congressional approval of Medicare and Medicaid. Explaining the move to Wilbur Cohen, the administration's point man for crafting the legislation, Johnson said: "Don't you understand? I'm doing this for Harry Truman. He's old and he's tired and he's been left all alone down there. I want him to know that his country has not forgotten him. I wonder if anyone will do the same for me."⁴

The signing took place before thirty-three members of Congress and numerous other officials and citizens. Johnson sat at the same small table President Truman had used in 1947 when he signed the Truman Doctrine legislation that initiated aid to Greece and Turkey. The former president gave a brief welcoming speech, declaring his pleasure at having lived to see the signing of the bill. Johnson expressed pride that the bill had passed during his administration and thanked the invited guests who had contributed to its passage. He used 72 pens to sign his name. He gave the first pen to Truman, the second to Truman's wife, and the remainder, plus an additional 150 pens, to other guests. The entire ceremony lasted only twenty minutes.⁵ Brief and bland, it belied the rancorous and protracted political maneuvering that preceded it.

The first serious bill to promise universal health insurance was introduced in 1939, during Franklin Roosevelt's second term. With metronomic regularity, similar bills were reintroduced in each succeeding Congress and ignored. No hearings were even held on the proposal President Truman endorsed in 1949.

When John Kennedy tried to deliver on a campaign promise of hospital insurance for the elderly, the idea failed to win approval in the House Committee on Ways and Means. The committee's formidable chairman, Wilbur Mills (D-Ark.), knew that he lacked the votes to move the bill (it was not even clear that he wanted to do so). The majority of the committee, which comprised conservative Republicans and southern Democrats, strongly opposed the Democratic proposal for hospital insurance financed

by a mandatory payroll tax. The Republicans favored a voluntary, premium-, and tax-financed plan to cover physician bills. The southern Democrats feared—correctly, as events later proved—that federal payment for hospital services would help enforce equal access for blacks and whites in the still-segregated South.

Then came President Kennedy's assassination and the Democratic landslide of 1964. Many members of the enlarged Democratic majority hailed from northern and western states. They were disposed to support Medicare on the House floor. Some took seats on the Ways and Means Committee. It became clear that hospital insurance might pass the Ways and Means Committee even without Mills's support. Instead of opposing the bill, however, Mills designed a compromise that combined mandatory hospital insurance financed by payroll taxes (the Democrats' plan) with voluntary coverage of physicians' services financed by premiums and general revenues and extended means-tested health coverage of the poor (the Republicans' plan). The first two components constitute Medicare, the third Medicaid.

The original hospital insurance proposal met with strident criticism from other quarters as well. Some said Medicare would deny patients the freedom to seek the kind of care they wanted and would stop physicians from practicing medicine as they thought best. The president of the American Medical Association (AMA), Donovan Ward, likened the AMA's fight against Medicare to Winston Churchill's stand against the Nazis.⁶ He labeled the plan a deception that would endanger the relationship between patients and doctors. According to Milford O. Rouse, speaker of the House of Delegates of the AMA, the battle to defeat Medicare was a battle for "the American way of life" and "the protection of the sick."⁷ Perhaps the most eloquent attack came from a politically active movie actor named Ronald Reagan, who warned that Medicare would invite socialism to "invade every area of freedom in this country" and force Americans to spend their "sunset years telling our children and our children's children what it was like in America when men were free."⁸ These jarring attacks embodied a political ideology that continues to fuel some criticisms of Medicare.⁹

The House approved the bill 313-115. A somewhat different version passed the Senate 68-21. The House-Senate conference compromise was passed with similar majorities.¹⁰ Actuarial estimates put the cost of the final plan at \$3 billion a year (about \$19 billion in 2007 dollars).¹¹

History after Enactment

Since 1965, the character of health insurance in the United States has changed greatly. Health maintenance organizations and managed care have recast the typical job-based health plan. Private plans have linked insurance and delivery of care. In contrast, Medicare's system of parallel but separate plans—called Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI, or Part B)—preserve the typical 1965 insurance configuration of the separate Blue Cross and Blue Shield plans. The major changes have been the addition of managed care (Part C), as an alternative to Parts A and B, and an outpatient prescription drug benefit (Part D).

Whereas private insurance has become more integrated, Medicare has been slow to adapt to changing medical practice, beneficiary needs, and societal expectations. Decades passed before the program covered outpatient prescription drugs and preventive services that are of increasing importance to the elderly and people with disabilities. It still provides minimal coverage of mental health care and nursing home stays that do not follow hospitalization. And it does not cap out-of-pocket spending, now a benefit under most employer-sponsored plans. To fill these gaps, as well as to reduce Medicare's steep cost sharing, most beneficiaries seek supplemental protection. Some supplemental coverage comes from former employers or unions and some from individual purchase of so-called Medigap insurance. Many poor Medicare beneficiaries are also dually eligible for Medicaid, which pays for premiums, cost sharing, and additional services.

Although the growth of per capita Medicare spending has paralleled that of private insurance, Medicare spending has outpaced other federal spending. Moreover, Part A spending has grown faster than dedicated revenues, causing periodic "trust fund crises." These trust fund imbalances as well as Medicare's benefit gaps have triggered three major changes and small modifications since 1965.

Catastrophic Coverage Act of 1988

In 1988 Congress enacted the Medicare Catastrophic Coverage Act (P.L. 100-360). The title referred to the bill's coverage of large outlays but ironically turned out to describe the law's political fate. Proposed by the Reagan administration, the new law was passed by a Democratic Congress with bipartisan support. Among its numerous benefits, the act lowered deductibles and removed coinsurance and time limits on hospital coverage,

increased skilled nursing home coverage, removed all limits on hospice coverage, and covered outpatient prescription drugs above a deductible. The full cost of these added benefits was offset by an added premium paid by roughly 40 percent of Medicare enrollees with the highest personal incomes.

Having yielded to the pressures of both the Republican administration (which wanted beneficiaries to pay all of the added cost of the new benefits) and the Democratic Congress (which wanted progressive financing), the financing scheme doomed the entire law. Most of the cost of the new benefits fell on a minority of Medicare beneficiaries, many of whom were slated to pay far more in taxes than the value of the benefits they received. Others mistakenly thought that they were net losers. Many Medicare enrollees already had most of the new benefits from former employers. For them, the bill brought nothing but higher premiums. Worse still, premium increases were to take effect before the new benefits were available. The putative beneficiaries protested loudly and, on occasion, violently. Just sixteen months after its enactment, Congress overwhelmingly repealed the law.¹²

The Balanced Budget Act of 1997

The next several years saw a pair of major proposals and setbacks for both parties. President Bill Clinton proposed to cut Medicare's payment rates and add a drug benefit in his 1993 health reform plan. These Medicare changes died along with the rest of the plan in 1994. In 1995 the newly ascendant Republican congressional majority tried to cap Medicare outlays and lower spending by an estimated \$270 billion over seven years. Clinton vetoed the bill containing this provision, but he put forward a compromise proposal that led to bipartisan legislation in 1997.¹³

Official projections that year indicated the HI trust fund would be insolvent in 2001.¹⁴ To forestall that event and reduce the overall federal budget deficit, Congress enacted the Balanced Budget Act of 1997 (P.L. 105-33). Unlike virtually any Medicare legislation before or since, it was hailed as a victory by both parties. This bill included reductions in the growth of provider payments. It shifted some Hospital Insurance (Part A) costs to Supplementary Medical Insurance (Part B), lessening pressure on the payroll-tax-financed HI trust fund but forcing Part B premium increases. The bill also intensified official efforts to root out inappropriate and fraudulent payments to providers. It improved preventive benefits and low-income beneficiary protections and created a Medicare commission to identify policy ideas for the program's long-term challenges.

Following this legislation, nominal Medicare expenditures per beneficiary fell in 1998, the first absolute decline since the program was enacted. Responding to provider complaints, Congress repeatedly raised reimbursement rates.¹⁵ Even with these “give-backs,” the bill pushed back by twenty-eight years the date of insolvency for the Hospital Insurance program according to the 2001 Annual Report of the Medicare Trustees.¹⁶

The Medicare Modernization Act of 2003

Aside from the Catastrophic Coverage Act, most Medicare legislation before 2003 was triggered by projected insolvency in the HI trust fund or by overall budget deficits. Typically, such legislation modestly altered the program and left no lasting political rancor. In contrast, the Medicare Modernization Act of 2003 (MMA, P.L. 108-173) significantly changed Medicare, and its manner of passage aroused resentments that will shadow future Medicare reform efforts.

Focusing on his 2004 reelection challenge, President George W. Bush made passage of a prescription drug benefit a top legislative priority for 2003. By leading a successful effort to improve Medicare, the president hoped to show that a Republican-controlled executive and legislature could deliver on a promise made often, but never fulfilled, to extend Medicare to cover prescription drugs. He also pledged to advance a conservative vision by linking high-deductible plans to health savings accounts and by encouraging enrollment in private Medicare plans.

In June 2003 the House and Senate passed different versions of the legislation. The House, divided along party lines, produced a bill closely resembling President Bush’s vision. The Senate bill drew bipartisan support. Under normal procedure, a conference committee including both Republicans and Democrats from both chambers would have fashioned a compromise that both houses could pass. In this case, however, the Republican majority invited no House Democrats to participate and only two Senate Democrats—Max Baucus (Mont.) and John Breaux (La.)—both of whom accepted aspects of the House bill that most Senate Democrats opposed. Financial considerations further complicated negotiations: the total cost of the bill could not exceed \$400 billion, a ten-year spending limit imposed by the budget resolution of fiscal 2004.¹⁷ Despite these snags, the conference committee completed its work in November 2003.

However, passage was not assured. Most Democrats remained strongly opposed to the bill. Some Republicans also rejected any increase in a program they regarded as already careening toward insolvency; others thought

that the final compromise emasculated provisions in the House bill designed to promote competition. House floor debate was acrimonious, initially presaging defeat. But the Republican leadership extended the usual fifteen-minute voting period to almost three hours, during which it rounded up a narrow, largely partisan, majority.¹⁸ House Democrats were furious but helpless. Senate debate was no less contentious, because Democrats believed that they had been inadequately represented in conference. In the end, however, enough Democrats joined the Republican majority to pass the bill, expanding Medicare's benefit package to include outpatient prescription drugs.¹⁹

The benefit (see chapter 2) is delivered in two ways: through stand-alone prescription drug plans (christened Part D) or through Medicare Advantage plans (Part C). The MMA also increased payments to private plans to promote them as an alternative to the traditional fee-for-service delivery system. In addition, the MMA changed provider payment rates, took some small steps toward rewarding quality care, and began to explore the potential of disease management. It also established a new measure of program insolvency based on the proportion of total outlays covered by general revenues.²⁰

The passage of the MMA did little to quell controversy. Representative Nick Smith (R-Mich.) charged that he had been threatened and offered a bribe during the three-hour-long vote.²¹ In March 2004 Medicare's chief actuary complained that during the negotiations leading to the final compromise he had been forbidden by Tom Scully, administrator of the Centers for Medicare and Medicaid Services (CMS) and a political appointee, to share with Congress his estimate that the bill would cost \$534 billion for the period 2004–13.²² Had the actuary's estimate—which was much more than the \$400 billion authorized in the fiscal 2004 budget resolution and the \$395 billion estimate of the Congressional Budget Office (CBO)—been made public, the conference agreement would likely have been defeated. After the bill was enacted, Democrats charged that the television ads, fliers, and news videos the administration prepared to inform seniors of their new options were misleading and represented veiled political propaganda. When the Government Accountability Office concluded that some of the videos were an illegal “covert form of propaganda,” the administration stopped their use.²³

Once the drug benefit went into effect in 2006, its implementation was relatively smooth. Within a year, all areas of the country had a private drug plan, enrollment rose, beneficiary satisfaction was high, and expenditures turned out to be lower than originally projected by both the CBO and

CMS. Even so, the MMA continues to be hotly debated, particularly because of its prohibition on government involvement in drug price negotiation and the role of private plans in Medicare. In all likelihood, its new insolvency measure will provoke new debates on how to reform the system.

Future Challenges

Medicare has by and large met its goals of providing affordable access to health care for the elderly and persons with disabilities (see chapter 3). Moreover, access is comparable to that provided by private insurance, and the growth in per capita spending is close to that of private plans. As for satisfaction, a 2001 survey found elderly Medicare beneficiaries nearly three times more likely than enrollees in employer-sponsored plans to rate their health insurance as excellent.²⁴

All the same, Medicare policy will no doubt invite further debate. Many continue to object to government-managed health insurance on principle. Others still question whether Medicare covers too much or too little of its beneficiaries' health expenditures. And a good number balk at growing program outlays.²⁵ Cost-containment efforts, precipitated in the past by the desire to limit federal spending and by projected insolvency of the HI trust fund, will now focus on the degree to which the entire program relies on general revenues.

Cost

Between 2008 and 2018, Medicare's share of non-interest federal spending is expected to rise from 14.8 to 17.1 percent.²⁶ As a result, the program will put steadily increasing pressure on the rest of the government budget (chapter 3). The MMA intensified those pressures, widening the projected federal budget deficit by an average of 1 percent of gross domestic product over the succeeding seventy-five years.²⁷

Fast-rising costs are bound to impose major new burdens on individual beneficiaries, as well as taxpayers. Out-of-pocket spending on health care for seniors equals about 45 percent of their Social Security benefits and could surpass 60 percent by 2030.²⁸ These shares will be even higher for those with above-average medical expenditures. If rising outlays buy services that are worth what they cost, they will signal a huge increase in the well-being of Medicare beneficiaries due to improved health care services. Even so, the financial readjustments necessary to divert resources to Medicare will be troublesome.

Access

The modest expansion of Medicare's covered services has failed to allay concerns about benefit adequacy. Cost sharing for some services remains high. The duration of coverage for hospital and skilled nursing home stays is limited. Before enactment of the MMA, Medicare covered nearly half of the health and long-term care expenses of its beneficiaries.²⁹ As detailed in chapter 2, beneficiaries have to pay premiums, deductibles, and other cost sharing, not to mention fees for uncovered services. Those with serious medical problems can incur catastrophic out-of-pocket expenses if they do not have supplemental coverage.

Such insurance has become increasingly costly and hard to find. These trends are likely to continue. A 1990 decision of the Financial Accounting Standards Board required businesses to recognize on their balance sheets a liability for the present value of projected medical benefits for their current and future retirees.³⁰ A similar policy is going into effect for the public sector, which has historically provided retiree coverage. Although the liabilities are not new, their heightened prominence on private employers' balance sheets is thought to depress share values. Accordingly, many businesses have curtailed or discontinued once-generous retiree health benefits. The proportion of large firms offering retiree health coverage fell from 66 percent in 1988 to 33 percent in 2007.³¹ Many retirees who still have employer-sponsored policies are seeing a sharp increase in premiums and co-payments—10 percent in 2006, even with the addition of the drug benefit.³² Medigap, too, has been on the decline, as fewer seniors have been able to afford its premiums.

Plan of the Book

For those who are not familiar with the Medicare program, we begin in chapter 2 with a detailed description of Medicare's structure and financing. Readers who are generally familiar with how Medicare works are advised to skip chapter 2. Chapter 3 assesses the program's current performance in providing affordable, accessible, high-quality coverage. Next, we take up three strategies for program reform (chapters 4–6): updated social insurance, which would retain the current system while rationalizing coverage and reducing bureaucracy; premium support to replace the current system with

a capped, per person payment that beneficiaries could use to buy health insurance; and consumer-directed Medicare, wherein beneficiaries would pay for care up to a high deductible from government-supported savings accounts and receive premium-support coverage above the deductible. We then evaluate these strategies against program objectives and rate their political strengths and weaknesses (chapter 7).