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PROSPECTS AND IMPLICATIONS OF MEDICARE REFORM FOR HOUSEHOLDS

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EXECUTIVE SUMMARY

Medicare is crucial to the financial wellbeing of retirees. Calls for Medicare reform need to proceed with caution to ensure the program continues to support retiree financial security. Medicare serves over 40 million of the most-difficult to insure patients, many of whom lack the resources to pay the full costs of their healthcare. For many providers of healthcare services, it is the largest source of revenue, and its rules and regulations affect all health care delivery. Any major reform must take into account these stakeholders, creating a substantial public policy challenge. While there are no easy answers, there are options for change that hold considerable promise.

Medicare began in 1966, initially operating much the same way as other insurance of the time; it simply paid the claims submitted by those who provided services. Early growth in the costs of Medicare arose from the addition of the disabled population, and increased prices and use of services. A period of reforms aimed at reducing prices began in the late 1970s, and since then, substantial adjustments have been made to payments to providers of care as well as some more systemic changes. Over its history, Medicare spending indicates that it is neither less efficient than the private sector, nor does it provide overly generous benefits. Nonetheless, the prospect of higher spending as the Baby Boom retires has led to calls for reforming the program.

A wide range of options and approaches are possible. One key part of the debate is whether to adopt specific changes while leaving the current structure basically intact, or whether to turn to private insurance plans. Changes in the delivery of care can sometimes be accomplished more effectively by a centralized public entity and sometimes by the private sector. Under an incremental strategy, beneficiaries would continue to choose between traditional Medicare or a private (Medicare Advantage) option. But, private options would be required to prove their worth in coordinating care and/or offering other advantages, and any 'extra' subsidies they now enjoy would be reduced. The existing fee for service program would go through a number of reforms, including some of those described below.

Moving to a reliance on private plans would mean that beneficiaries would be given a voucher to purchase their own insurance, subject to certain rules and regulations placed on participating plans. It would then be up to the plans to develop approaches for holding down costs. The government would need to ensure that Medicare beneficiaries—including those with substantial health problems—have access to high quality care.

What are some specific savings options? The most often used is to reduce payments to providers of care, although there is now increasing concern about the willingness of doctors and hospitals to take Medicare patients. Other options focus on use of services. New technology is a major factor increasing health care costs, and since most new technology is not subject to scrutiny about its effectiveness before being adopted, another cost-saving option would limit coverage when evidence indicates little or no benefit. Another often proposed approach to reducing use is to increase cost sharing on patients. But health care costs are concentrated on only a few beneficiaries who would potentially bear very large costs for services that they should be receiving.

The number of people eligible for Medicare could be limited—either by increasing the age of initial eligibility or by excluding those with high income or wealth. The private market would have to be substantially reformed, however, for this to work since these individuals would otherwise increase the ranks of the uninsured.

All of these options would inflict additional controls and burdens on key stakeholders, but some of them will be needed to hold down the costs of Medicare over time. If Medicare is to remain a viable source of insurance for the population it serves, additional revenues likely will be needed as well.

INTRODUCTION

Reforming the Medicare program is a topic that arises periodically in the Washington policy arena, but a viable plan remains elusive. Given the program's burgeoning costs, "reform" is generally equated with finding ways to reduce the growth in federal spending—although quality of care and value are sometimes also included as goals. Moreover, since this is a public program and one supported partially by dedicated funding, it is subject to additional scrutiny. Despite the efforts of several commissions, it has been difficult to reach consensus among the many constituencies that have a stake in Medicare. Medicare serves a population of over 40 million of the most-difficult to insure patients, many of whom would lack the resources to pay in full for the costs of their healthcare. It is among the most popular of government programs. For many providers of healthcare services, it is the largest source of revenue. Its rules and regulations affect all of health care delivery. And finally, it is a large and growing share of the federal budget and Gross Domestic Product (GDP). Any major reform will affect all stakeholders in the economy, and at least some of them will be dissatisfied with certain details of the reforms, if not the entire package.

In response to varying stakeholder interests, many politicians have sought a magic bullet to hold down the costs to government while simultaneously continuing to deliver high quality care and keep providers of that care satisfied with the payments they receive and the controls placed on the program. Proposals for these magic bullets have shifted over time and in some cases (for example, with managed care and competition), options are being proffered a second time around, reincarnated in a slightly different form. Ultimately, there are no magic bullets; it is not possible to offer all the care people want at rates that providers of care want to charge while holding the line on spending. The closest any option comes to such a claim is the elimination of fraud, waste and abuse. But no serious analysis has ever suggested that this alone can address the need for Medicare reform in the future; indeed, evidence on exactly what is appropriate care is hard to come by and expensive to produce.

Nonetheless, there are options for change that hold considerable promise and the sheer cost of health care will drive the impetus for reform for the indefinite future. This essay explores evidence on the implications for various reforms. But first, it is important to establish some of the salient facts and debunk some of the incorrect assertions that confuse the issues.

WHAT WE KNOW

The Medicare program began in 1966, initially operating much the same way as other insurance of the time; it simply paid the claims submitted by those who provided services. And in the early years, there was relatively rapid growth in the use of services by a population that had been underinsured. But, the Medicare program did not change as much as did private insurance for the working population--which became more comprehensive over time, adding prescription drug coverage and reducing cost sharing. Medicare continued to cover about 60 percent of the costs of hospital, physician, and other acute care services until the prescription drug benefit was added in 2006. But even that important addition only increased Medicare's coverage to about 65 percent of the costs of acute care services.

Thus, the early growth in Medicare did not stem from an ever-expanding benefit package. Rather it arose because of the addition of the disabled population in 1972, increased use of some services, and the prices paid for the benefits. A period of reforms aimed at reducing prices began in the late 1970s, and in nearly every year in the 1980s, substantial adjustments were made to payment systems for various providers. Prices for specific services were reduced and some more systemic changes such as paying for a full hospital stay rather than each of its parts were made. These changes did hold down the rate of growth of program spending, resulting in rates of growth lower than growth in the private insurance sector in the 1980s.

Medicare then experienced a period of higher per capita growth relative to private insurance as the great shift to managed care in the employer-based insurance sector began in the last half of the 1990s. But that effort was short-lived. After considerable patient push-back, private insurance relaxed many of the greatest restrictions placed on care and costs once again began to rise. Managed care has proven to be difficult to do in practice for people of all ages. But more importantly, Medicare beneficiaries exhibited only modest interest in managed care as an option, and because they could remain in traditional Medicare, many chose to do so. Finally, the mechanism for paying private plans under Medicare resulted in substantial overpayments and as a result, the federal government essentially lost money on those who enrolled in the managed care options.[1]

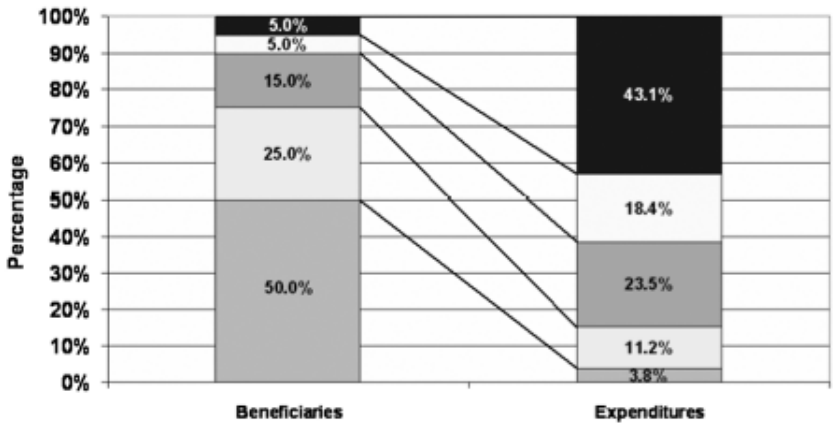
Despite this failure in the late 1990s, many policy makers remained interested in private plans as a key component of controlling costs over time. In 2003 legislation, lawmakers again added extra subsidies to encourage enrollment, resulting in higher benefits for patients who enrolled, higher profits to insurance companies, and once again, higher costs to the federal government. Because key stakeholders have become used to these higher payments, Congress may find it very difficult to use private plans to actually reduce costs to the Medicare program in the future.

Over its history, Medicare has largely mirrored the rest of the healthcare system. Overall, Medicare is neither less efficient than the private sector, nor does it provide overly generous benefits. Across the U.S. population, the cost of health care has risen faster than other goods (on average) as new technologies have been introduced and spread rapidly. In general, Americans rely more on technology than other countries. We do more tests, and use expensive new drugs and treatments. Further, Medicare spending, like health spending by the rest of the U.S. population, is highly concentrated among a modest number of the very sick. Figure 1 indicates how health spending is distributed for Medicare. This figure demonstrates that, in any year, a small proportion of beneficiaries account for a sizable proportion of Medicare spending and half of the beneficiaries account for nearly all Medicare expenditures. For example, in 2001, five percent of beneficiaries accounted for about 43 percent of expenditures and 50 percent of beneficiaries accounted for about 96 percent of Medicare expenditures. Some people cite care at the end of life as the major problem. It is expensive and overuse occurs there, but it is not the dominant explanation for high spending by the Medicare population. Rather, it is a combination of expensive hospital care for a small proportion of beneficiaries and treatments for persons with chronic diseases that require persistent care over time that keep costs high.

1 A full discussion of these issues is beyond the scope of this paper. A brief review of the literature discussing these issues is outlined at the end of this essay for those desiring to pursue these issues in more detail.

Many analysts agree that these areas require better coordination of care rather than a change in the generosity of benefits.

FIGURE 1.
CONCENTRATION OF ANNUAL MEDICARE EXPENITURES AMONG BENEFICIARIES, 2001



Source: CBO based on data from CMS.

SORTING OUT THE OPTIONS FOR REFORM

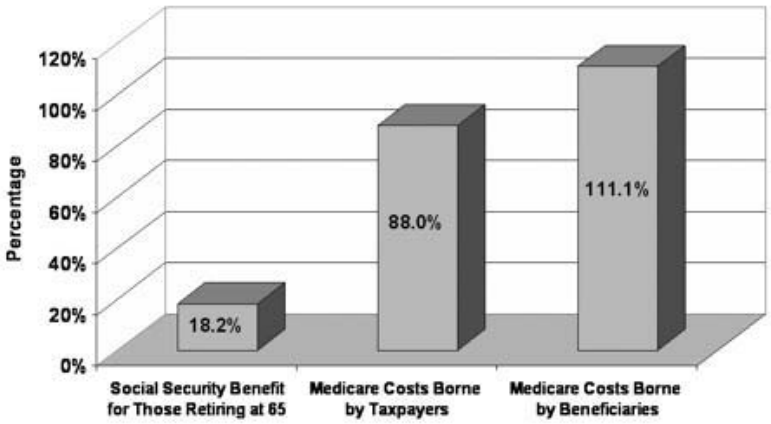
Technically, the overall costs of the Medicare program rise because the prices paid for services, the quantity of services provided, and the number of beneficiaries enrolled goes up each year. Options for reducing costs need to tackle one or more of these issues. That is, lowering payments to providers of care, limiting use of services, and/or limiting eligibility for the program are the ways to slow cost growth over time.

It is, however, important to distinguish between changes that reduce the overall costs of care and ones that just shift costs to some other part of the system. For example, it is possible to reduce the number of people getting Medicare and hence reduce federal spending, but that does not necessarily reduce the costs of healthcare to society as a whole. The same is true for changes that require beneficiaries to pay more for the costs of their own care. While they may reduce their use of some services, a substantial part of any savings comes from simply shifting costs to the beneficiary. Unless very carefully designed, studies show that higher cost sharing discourages both necessary and unnecessary service use. And the patients most likely to reduce use of care are those with lower incomes, for whom the cost sharing is a substantial burden. Essentially these options relate more to the question of financing—that is, who is going to pay for the costs of care—than to "reform." When evaluating greater beneficiary contributions, it is better to consider what the division of burdens between taxpayers and beneficiaries should be. Since higher revenue from taxpayers is politically the most difficult option to propose given the mantra of "no new taxes," implying that additional new revenues is the least likely option to be openly advocated by politicians who fear the wrath of voters.

But recognize that a decision to hold the line on spending through premium increases or even limits on eligibility implicitly answers the question of who should pay as "beneficiaries, not taxpayers." But when tackled more directly, the answer needs to be based on the resources available to each of these groups. For example, direct shifting of new burdens on Medicare beneficiaries will come on top of the share of spending they already bear. Over time, the

existing burden on beneficiaries will grow even faster than the "unsustainable" growth in federal Medicare, and much faster than the incomes of the elderly and disabled. In previous research, I estimated that Medicare cost sharing and premiums will rise by 111 percent per capita through 2030 (even after controlling for inflation), while Medicare spending per capita is projected to rise by only 88 percent. In contrast, it is estimated that the benefits to a newly enrolled Social Security beneficiary will rise by less than 20 percent by 2030 (see Figure 2). These trends will result in health care payments rising substantially as a share of income for older Americans because Social Security benefits make up a substantial source of retirement income for most Medicare beneficiaries.[2]

FIGURE 2.
EXPECTED GROWTH PER CAPITA 2007 TO 2030



[2] For 2004, about 90 percent of the population aged 65 or over received Social Security benefits. As a share of total income, Social Security comprised about 39 percent for this group, and accounted for about 53 percent of income for those over the age of 80.

Alternatively, costs to the Medicare program could be reduced by limiting the number of people eligible to receive Medicare—another form of cost shifting. Two major approaches are usually suggested—either raising the age of eligibility or limiting eligibility to people with lower incomes. In the first instance, people would have to pay for their own care in the earlier years of retirement, effectively increasing costs on all older Americans. In the second example, the impacts would be limited to a small proportion of older Americans. In both cases, however, the number of people taken off the roles would be relatively small. For example, raising the age of eligibility from 65 to 67 would cut the number of beneficiaries by about 5 percent, but reduce costs by only 2 percent (since the 65 and 66 year-olds are the lowest cost beneficiaries on average). And an income-tested benefit would have to begin to cut individuals from the program whose incomes are quite modest if the goal were to save as much as 5 percent of costs. This would substantially change the nature of the program, perhaps undermining its base of support.

If government spending is the only issue of concern, then cost shifting is an acceptable option, but if the goal of reform is to reduce healthcare spending overall, the range of options change. Moreover, many healthcare analysts make the point that Medicare's problems are essentially those of the healthcare system as a whole, and the debate needs tobe more expansive than focusing on just this portion of the population.

2 For 2004, about 90 percent of the population aged 65 or over received Social Security benefits. As a share of total income, Social Security comprised about 39 percent for this group, and accounted for about 53 percent of income for those over the age of 80.

WAYS TO IMPROVE THE OPERATIONS OF THE MEDICARE PROGRAM

Many different types of options can fall under the rubric of improving Medicare. Options could be adopted incrementally or rolled into a major reform by turning the problem over to private insurance; in fact, the major area of disagreement for much of the reform debate is who should control the way that care would change for the elderly and disabled. Whoever is in control, the key changes needed essentially remain the same. The various changes in the delivery of care can sometimes be accomplished more effectively by a centralized public entity and sometimes by the private sector.

First consider the issue of payment for care. Over the last two decades, Medicare saved substantial resources by reducing what it paid for services (with some of these reductions shifted onto other payers, its payment levels are now such that some providers, particularly physicians, are beginning to threaten to refuse to take Medicare patients if further cuts are made). Ironically, Medicare payment levels today are actually closer to those of the private sector than in the 1980s when stringent cuts in Medicare payments were made. In the 1990s, the private sector also began to be more aggressive in limiting payments to providers. But whoever controls Medicare, private insurance for younger families can no longer be used to cross-subsidize the costs of care by paying more than their share of the costs. With less fat in the system than in the past, it is not clear to what extent Medicare can rely upon further payment limitations without affecting access to care by beneficiaries. This has not happened on a large scale as yet, although in some areas of the country, physicians are less willing to take Medicare patients. Rebalancing differences in use of services and payment by geographic location is an important piece of any solution, but will likely be a daunting challenge whoever controls the system.

On the other hand, health care costs in the United States continue to be substantially higher than in other countries for the same types of services. The high payments to U.S. providers of care and to companies that supply goods (drugs, medical supplies, durable medical equipment) are testimony to our willingness to pay for the care we get. On a crossnational basis, there would appear to be room for more efforts to at least slow the growth in prices paid for services.

Reducing the quantity of services provided to each Medicare patient also raises major challenges regardless of who is in charge. Costs are rising in no small measure because of the introduction of new technologies and treatments in medicine. In fact, a number of studies have suggested that technology accounts for about half of the rising costs of healthcare. It is now possible to do more than ever before and to serve patients who might not have been good candidates in the past because of their advanced age or general level of health. It is also the case that, in general, new technologies have not proven to be lower cost than past treatments. Often new technology is simply added on top of other tests, treatments and drugs. Thus, while technology means more can be done and sometimes with better outcomes, it generally costs more. Unfortunately, we tend to adopt new products and treatments before they are thoroughly reviewed for their effectiveness. Consequently, studies indicate that care in the United States uses new technology when older technology works just as effectively, and there is considerable overuse of services. Finding effective ways to improve the efficiency and delivery of healthcare is not a simple task, however.

Tackling the use of care requires changing the incentives that patients and payers face in making choices about use of care. The original promise of managed care is that it focuses on the whole range of spending, and hence should steer patients to the least costly way to treat problems and hold down costs over time. A managed care organization should recognize the importance of providing the right balance of care to keep the individual healthy to avoid later high expenses. Plans paid a fixed amount have an incentive to pay attention to overall service use as opposed to the incentives of a fee-for service system where each provider of care is compensated separately. The successful managed care plans (and their patients) often have a very different philosophy about care than those who stress the more laissez faire approach of a fee-for-service system. They depend upon acceptance of tight coordination and control.

The less tightly controlled managed care organizations (which make up the majority) are generally less successful in coordinating care or affecting costs. On the other hand, this broad incentive can also result in inappropriate denials of care.

In fee-for-service plans, providers have an economic incentive to do more since they are paid on a piece-rate basis. And individuals, seeking to coordinate their own care, often visit many providers in search of high quality care. But, it may also be possible to change incentives for providers in traditional fee-for-service Medicare to emphasize coordination of care on a smaller scale than full managed care. Primary care physicians could be enlisted to offer a "medical home" to beneficiaries, coordinating their care and reducing the need for as much reliance on specialists and multiple providers. Such an option could use higher payments to physicians who provide better preventive services, coordinate the use of care, track prescription drugs and better manage those with chronic conditions. These are all areas that studies suggest contribute to unnecessary and inefficient care. This is taking the philosophy of much of managed care but applying it in a less restrictive environment, and perhaps in ways that more patients would accept. The downside is that incentives to overutilize care (arising from paying more when more is done) would still exist and primary care physicians might not serve as strong a gate-keeping function as would be needed to more carefully manage care.

Another promising area for improving quality and in some cases reducing costs would be to fund more research and dissemination of information on best practices. Coverage of prescription drugs, tests and treatment could be limited when evidence suggests that little or no benefit would result either in a comparative sense or absolutely. For example, once a high quality drug for blood pressure is identified, there is no reason to pay for more expensive versions of "me too" drugs. Slowly, more treatments and products are being subjected to such tests and a system can operate at high quality without covering all possible available care. For this to work in practice, however, there needs to be more investment in high quality analysis needed, and just as importantly, buy-in from physicians and patients alike into a more evidence-based approach to health care delivery. Medicare could serve as a role model, eliminating coverage of duplicative and costly products and treatments that do not meet the standards of improving health. Funding of such work needs to be done at the broadest possible level, since no single insurance company, for example, would want to pay for research that would also help its competitors. This implies an approach that does not break Medicare into many separate private insurance entities.

On the other hand, private insurers do not have to be burdened with the due process rules that can hamstring a government program and reduce its flexibility. Introducing new techniques or redirecting care can be done more rapidly by the private sector (but sometimes more arbitrarily as well).

Finally, yet another approach to reducing use of services is to change the incentives for patients by making them responsible for a greater share of the costs of care, either with initial high deductibles or greater cost sharing. This option remains popular particularly in a fee-for-service environment, but it is largely untested; the key challenge is that health care costs are concentrated on only a few beneficiaries who would potentially bear very large costs for services that they should be receiving. Moreover, studies have shown that patients are not very skilled at distinguishing between unnecessary care that they could forego and services that they need. High deductibles and across-the-board cost sharing increases are rather crude tools. If this approach were to be used, it makes more sense to apply it to everyone (with protections for those who could not afford the higher contributions). When offered as one of many options, those who enroll tend to be a healthier and wealthier households for whom the high deductible is not much of an issue, thus defeating the purpose of encouraging less use of care. In this case, "choice" becomes a negative, not positive, characteristic of a privatized system.

Most of these options would inflict additional controls and burdens on key stakeholders, but some variation on these approaches will be needed to hold down the per capita costs of Medicare over time. But the most heated debate over

Medicare's future actually centers on who would be in charge of implementing such changes and comes down to the basic ideological question Americans are grappling with across many areas of public policy—which do we want to rely on: government or the private sector?

A COMPREHENSIVE PRIVATIZATION APPROACH VS. A MORE INCREMENTAL STRATEGY

As noted above, private insurance and a single governmental approach to Medicare each have advantages and disadvantages in applying some of the changes likely to be needed over time. The two basic choices under debate are keeping Medicare essentially as it is today, while implementing a number of incremental reforms vs. moving to a system in which the federal government's role is essentially that of paying subsidies to private insurance companies which then provide care to all Medicare beneficiaries. Consider how each of these could operate.

Under an incremental strategy, the existing arrangement of allowing beneficiaries to choose between traditional Medicare or private (Medicare Advantage) options would be retained. But unlike the current system (that allows essentially any private plan to participate), private options would be required to prove their worth in coordinating care and/or offering other advantages. Private plans could then become an explicit way for Medicare to discover improved methods for organizing, coordinating, and delivering benefits. Evaluations of these activities would need to occur and be shared rather than the current practice of keeping any new techniques proprietary. Plans, for example, could focus on the needs of specific groups such as those that need highly coordinated services. Payments would be established that would create a level playing field with traditional Medicare; this change to reduce subsidies to private plans alone would likely cause many (such as the currently expanding private fee-for-service plans) to leave the market. This would save money for the federal government and reduce some of the abuses on beneficiaries that now occur under some private plans.

Investments in new roles for primary care physicians to coordinate care and in research on more effective care would also be important components of an incremental approach. Federal payments to physicians and cost sharing would be modified to reflect evidence and to steer patients to more appropriate care. For example, the prescription drug benefit could be redesigned to lower beneficiaries' cost sharing on the drugs deemed most valuable and effective, and increase beneficiary cost sharing or even eliminate coverage for drugs that are simply more expensive with the same impact.

These changes would not always be popular; and one challenge of doing this through a government-managed program would be to keep lawmakers from micro-managing the system in response to lobbying from the powerful healthcare industry. Indeed, this is one of the key reasons why some lawmakers support relying on the private sector. Combining that goal with the hope that more competition and choice itself could hold down costs explains much of the support for using the private sector to manage care for the elderly and disabled.

Moving to a system of private plans would require considerable change. And, as a "comprehensive" reform approach, both its claims of benefits and the concerns about costs are on a grander scale than an incremental view. Private managed care plans have not been popular options when individuals have a choice of remaining in a fee-for-service setting (and with a level playing field). After 2003, policy makers offered "carrots" to Medicare beneficiaries to enroll by paying extra to private plans, which then pass extra benefits on to their enrollees. Even with these inducements, only about 20 percent of Medicare beneficiaries have enrolled in private plans, and most of the recent growth has been in the private fee-for-service options, which do not manage care in any way. A private approach would need to require beneficiaries to choose and enroll in a private plan.

Under a system of private plans, a key issue is what role government should play in setting premiums. If plans are not constrained, the government would face paying subsidies with no ability to control costs. For that reason, most

proponents of a private approach argue for moving to a defined contribution scheme.[3] Private plans would have to find ways to offer all benefits at an affordable price and hence pay attention to the overall costs of care. It would be their responsibility, and not that of government, to worry about how fast costs would rise over time. Rather than guaranteeing, as Medicare currently does, a basic benefit package at whatever it costs to deliver such benefits, the government would instead establish an amount that it is willing to pay for each beneficiary each year. Each individual eligible for Medicare would receive a voucher with which to purchase an insurance policy. This would essentially create a "defined contribution" rather than a defined benefit guaranteeing a certain package of healthcare goods and services. Key to the impact of a defined contribution approach is whether beneficiaries would face a market much like the one that individuals under age 65 without employer-based coverage now face, or if new mechanisms would be set up to regulate the market. The latter case would keep government more involved in health care to establish oversight of insurance products and marketing. Opponents of government involvement usually stress that market forces would act as a regulating mechanism.

Supporters of this defined-contribution approach believe that vouchers would make beneficiaries and insurers more conscious of costs. By offering a fixed subsidy to beneficiaries, individuals would have the incentive to shop carefully to find the most efficient plans. The advantages, from the perspective of voucher plan supporters, are the increased choice and competition that the market can foster, presumably resulting in higher-quality benefits at lower costs for beneficiaries. Since 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.

Supporters also often suggest that moving to reliance on private plans would generate savings that would arise from greater efficiency and savings that result when plans compete. But as discussed above, there is considerable reason to question this claim. Per capita costs under traditional Medicare have risen at a rate comparable to or below that of private plans. Coordinating care is done in practice by only a few managed care plans, usually those that have very strong networks and a longstanding philosophy about managed care. Overall, if private plans of all types are encouraged, many plans will not live up to the goal of coordinating care and holding down its costs.

On balance, vouchers offer less in the way of guarantees for continued protection under Medicare. Marketing abuses, exclusionary practices and other undesirable behavior in the individual private health insurance market do not bode well unless Medicare takes an active role. And even then, there are considerable reported abuses under Medicare's current Medicare Advantage option allowing private plans to participate in serving Medicare beneficiaries. The complexity of the insurance market makes the potential for abuse very high.

Further, while it is likely that the voucher would be adjusted by the health status of the beneficiary, if the amount is not enough to compensate plans for taking on sicker beneficiaries, the most vulnerable individuals would be at greater risk. A voucher program where the government controls only its share of the costs of insurance may result in considerable risk selection and cream skimming. That is, plans could offer better coverage for services that healthy beneficiaries use as compared to those used by sicker beneficiaries, attracting a less expensive mix of patients. While some of this occurs under the current system of private plan options, traditional Medicare is there as a fallback option and plans are more carefully regulated than they would likely be under a system where government does little to interfere with healthcare issues.

Vouchers are perhaps most appealing as a way to substantially control the federal government's contributions to health care rather than to reforming the system overall. Many critics of the current Medicare program refer to it as unsustainable because of its high rates of growth over time. To the government, vouchers have the appeal of enabling a predictable rate of growth in the program. Indeed, that is the essence of a defined contribution approach—to allow for a predictable, controllable contribution over time. And, it is a rather subtle approach that avoids having

3 As discussed in the documentation on legislative intent for the 2003 legislation.

to explicitly reduce benefits or coverage. Again, that is where the claim of greater efficiency from the private sector over time protects the advocates of this approach from recognizing the rather direct shifting of both costs and risks over time.

This option is often presented as a combination of encouraging coordination through private plans and requiring beneficiaries to pay more of the costs of their care. Under such a system, the risks of the rising costs of health care over time 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, the government contribution might be set to grow at the rate of growth of the economy. If healthcare costs continue to grow as expected, the effect on beneficiaries implicitly would be the erosion of comprehensive coverage. Each year, the amounts would buy less and less health care coverage, forcing beneficiaries either to pay more or make do with less. Having the risks under such a plan shifted to beneficiaries is of particular concern in an era when pensions and retiree health benefits from employers are less certain and Social Security benefits may well be reduced.

A less dramatic approach could also be undertaken in conjunction with creating a system of private plans. Plans would need to bid and negotiate rates, report on quality, and meet other requirements. This could soften the problem of poor information and a constrained health market, for example. But it would be more intrusive and contrary to the goals of many of the supporters of a "free market" approach. Unfortunately, free markets do not appear to operate well in the current health care system and market regulation is likely necessary for the foreseeable future.

CONCLUSIONS

The Medicare program will need to change over time. If it is to remain a viable source of insurance for the population it serves, it is highly likely that additional revenues will be needed. Nonetheless, that will not be the first area in which changes are likely to be made. Rather, continued efforts to find ways to hold down the costs of care will be debated and some implemented. Whether this is through major reforms, turning the system over to the private sector, or from more incremental changes to Medicare, better coordination and assessment of care will be needed. Changes that affect the delivery of care need to be viewed in terms of the full healthcare system and not just Medicare. Without strong consensus on what to do and with heavy scrutiny of any changes made by stakeholders, Medicare will need to be periodically re-examined.

A NOTE ON REFERENCES

A number of claims were made in this essay that can be backed up with a rich supply of studies and analyses. But rather than adding formal footnotes, they are referenced here for those who wish to read more about the many issues raised in this paper. Key and sometimes controversial issues raised here include: The effectiveness of managed care, particularly with regard to the Medicare program;

- The sources of cost growth in Medicare;
- The role of technology in raising health care costs;
- Using cost sharing to "discipline" health care spending; and
- The implications of shifting to a set of private plans to serve Medicare beneficiaries.

Elsewhere, I have written a considerable amount about the Medicare program, most accessibly in a book from the Urban Institute Press. As noted in this essay, I am skeptical about the promise of private plans for Medicare. I have written specifically about this in a Health Affairs article with Cristina Boccuti. Others, including Marsha Gold, also outline some of the challenges for these private plans. Certainly others offer a different view and these can be found in writings from several organizations including the American Enterprise Institute and the Cato Foundation. Alan Enthoven is perhaps the most respected and articulate voice in this area.

For specific discussions of health care cost growth and the role that technology plays, see studies by Newhouse, Cutler, Aaron and the Congressional Budget Office cited below. While it is always difficult to parse out the exact impact of technology, it seems to account for nearly half of cost growth. The issues around cost sharing can be found in the original work on cost sharing by the Rand Corporation. This work is often cited in support of using cost sharing, but the more complete analyses indicate that low income people are more affected and that individuals cannot easily distinguish between necessary and unnecessary care. Tom Rice also writes eloquently about this.

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