Abstract: Any restructuring or reform of Medicare should first and foremost preserve the integrity of the program. Contrary to current rhetoric, Medicare offers mainstream medical care for the most difficult-to-insure Americans, and over the past ten years its record of holding down costs has been better than that of the private insurance sector. For the very long term, when demographic changes place even greater pressures on Medicare, all dimensions of the program need to be considered in the search for a long-range solution, including asking beneficiaries and/or taxpayers to contribute more to the program. Expansion of managed care choices should certainly be part of any restructuring, but careful attention to improving the basic fee-for-service Medicare program—which will continue to serve a majority of beneficiaries for many years to come—also is needed.

Medicare has opened the door to health care and greater economic security for the nation’s elderly and disabled populations. It has contributed to improved health and quality of life for millions of vulnerable Americans. Without Medicare, many of the program’s chronically ill beneficiaries would quickly exhaust their financial resources.

Yet changes are dictated by the projected insolvency of the Medicare Hospital Insurance (HI) trust fund by 2002, rapid growth in Medicare outlays in an era of federal budget deficits, and the looming retirement of the baby-boom generation. Medicare now faces two problems (brought on in part by its own success): continuing to ensure access to care and financial security for beneficiaries while stemming unsustainable cost growth.

Grappling with the necessary choices will be extraordinarily difficult. Yet a reexamination of Medicare affords an opportunity for creative restructuring of the program to meet the growing health and long-term care needs of an aging population, while being cognizant of competing demands for the nation’s health care and budgetary resources. In this paper we argue that it is possible to build on the strengths and current structure of the Medicare program, while at the same time undertaking long-term changes to ensure its fiscal soundness. We offer pragmatic suggestions on how to improve the program while recognizing the substantial fiscal responsibilities ahead.

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Medicare has many strengths that should be retained, including some of the basic principles on which the program was founded.

**Universal social insurance.** Medicare provides universal health insurance coverage to nearly all persons age sixty-five and over and those who are permanently and totally disabled for two years or more. Because of Medicare, a far higher percentage of the elderly population (98 percent) have insurance coverage than any other population group. By offering a uniform benefit package and ready access to most health care providers, Medicare has achieved its goal of offering mainstream medical care even for the sickest and poorest members of the covered groups. There are, at present, few opportunities to discriminate against individual beneficiaries, thus assuring truly universal coverage.

This universality contributes to the program’s low administrative costs—disenrollment occurs primarily because of death. Medicare does not advertise; it does not pay commissions to a sales force; it does not pay profits to shareholders. Yet it uses private entities to perform functions when it can do so economically. It contracts with private insurers to pay claims. Health care services are provided by private hospitals, physicians, and other health care providers. Medicare also offers private health maintenance organizations (HMOs) to beneficiaries, with the requirement that HMOs return any excess profits to beneficiaries in the form of improved benefits.

Medicare’s universality has increased public support for the program and has eased the public’s anxiety about unpredictable medical expenses in retirement. It has corrected the private market’s failure to provide basic health insurance to a high-risk population. Finally, along with Medicaid, Medicare has tilted benefits toward lower-income recipients.

**Medicare’s risk pools.** One of Medicare’s strengths is its sharing of risks across a large population group. With thirty-seven million beneficiaries, Medicare is the largest risk group for health insurance in the United States. Effectively, costs for chronically ill eighty-five-year-olds are averaged in with those of healthy seventy-year-olds, making insurance less expensive than it would be if these eighty-five-year-olds were insured in the private market by a company that covered a much smaller number of persons. In addition, once a commitment has been made to treat all beneficiaries alike, the costs associated with underwriting and differentiating risks are forgone.

**Medicare’s discounts.** While Medicare has been criticized for not promoting managed care alternatives for its beneficiaries aggressively enough, the program is itself similar to a preferred provider managed care plan. Medicare sets prospective prices for hospitals and physicians at a substantial “discount” from usual charges. Medicare’s physician payments, for example,
average 68 percent of the physician fees paid by private health insurance plans.\textsuperscript{1} All providers are permitted to enroll, and physicians who agree to take “discounted” payments as payment in full become participating physicians. This has worked remarkably well; 92 percent of all Medicare physician services are now paid on this basis.\textsuperscript{2} Even when compared with formal preferred provider organizations (PPOs)—now the fastest-growing type of managed care in the United States—Medicare’s payment levels are much lower.\textsuperscript{3} Medicare’s payments to hospitals also are lower than the fees paid to hospitals by private insurers. Medicare has already achieved the discounts that are just now helping to hold down premiums for private insurers.

**Short-Term And Long-Term Problems**

Medicare faces two sets of financing problems. The first and more immediate is driven by high health care costs. The second is the demographic problem of a declining ratio of workers to retirees. The second problem will become severe when the baby-boom generation begins to become eligible for Social Security after 2010. Solutions for these two problems are likely to differ, but both need to be part of the debate about Medicare’s future.

In the current debate attention has focused on the near-term insolvency of the HI (Part A) trust fund. Part A is financed by a dedicated payroll tax, and its revenues and outflows are tracked by means of the trust fund. The most recent report on the status of this fund indicates exhaustion of its balance by 2002.\textsuperscript{4} That is, without any policy changes, the trust fund’s balance will drop rapidly from now until 2002. Actuaries have indicated that it will take $147 billion to keep the fund solvent until 2002.

This deficit is an artifact of the nature of Medicare financing. The Supplementary Medical Insurance (SMI) trust fund (Part B) is financed by premiums and general revenue contributions. It does not face insolvency because it has an unlimited draw on the federal treasury. The real issue, however, is not the solvency of the HI trust fund. If it were, its solvency could be assured by measures such as shifting Medicare home health benefits from Part A to Part B, which would make the HI trust fund solvent for nearly five more years; or increasing the payroll tax rate by 0.65 percent on both employers and employees, which would make the HI trust fund solvent for another twenty-five years; or adding general revenues as a source of financing the balance of HI outlays, which would make the trust fund solvent indefinitely as it does for the SMI trust fund.\textsuperscript{5} The HI trust fund originally was established to protect the Medicare program and to ensure that its revenues would not go to other government programs. The importance of the HI trust fund deficit today is much like that of the federal debt ceiling: It helps instill fiscal discipline and requires explicit policy choices.
periodically regarding Medicare spending and revenues needed to support it.

The real issue is the rate of growth of Medicare outlays—Part A and Part B—and the tax resources the nation is willing to commit to support Medicare. Because of Medicare’s size, no discussion of balancing the federal budget or changing tax rates is complete without examining whether to devote either more or fewer resources to Medicare. In fact, every year, Medicare has been a major focus of budget reduction efforts. While many of these efforts have focused on reducing payments to providers, some also have affected beneficiaries. As part of the 1994 budget reduction efforts, Medicare was cut by $56 billion over five years.

Medicare faces an even more serious financial crisis in the longer term in relation to the aging of the baby-boom generation and the changes that will occur as a result in the age distribution of the population. There will be fewer contributors to the system and more beneficiaries drawing from the system, making it very expensive to fund the program on a pay-as-you-go basis. At that time, Americans will need to decide how large a Medicare and Social Security program to support. Rational discussions concerning these changes need to begin immediately, although action can be deferred.

Vouchers And Managed Care: Promise And Concerns

In a difficult federal budgetary climate, capping the federal budget obligation for Medicare is an attractive policy option. Two types of proposals are receiving serious consideration: turning Medicare into a voucher program and increasing incentives for beneficiaries to join a wider array of managed care plans. These options represent mechanisms for capping budget outlays, shifting financial risk to individuals or health care providers, and creating incentives for individuals and providers to control costs.

While there are different types of voucher and managed care proposals, vouchers essentially cap the federal budgetary contribution and let beneficiaries choose their own private health insurance or managed care plan. If the premium for the coverage exceeds the amount of the voucher, the beneficiary pays the difference.

Most Medicare managed care proposals differ from vouchers in two important respects: (1) Only managed care plans that meet Medicare standards would qualify (with a fall-back fee-for-service option available directly from Medicare); and (2) Medicare would continue to set or negotiate a capitated payment rate. Managed care plans would not be permitted to charge beneficiaries more than Medicare’s payment rate.

Vouchers would provide more choices for beneficiaries but also would shift more financial risk to individuals. Under the managed care proposals,
most financial risk would be shifted to managed care plans or health care providers, although beneficiaries might have higher premiums depending on their choice of plan. Therefore, although vouchers and managed care proposals have some similarities—and hybrid proposals can have features of each—the philosophy behind the two approaches and their mechanisms for saving costs are actually quite different.

**Vouchers.** Advocates of a private-sector approach to financing health care for Medicare enrollees argue for a system of vouchers in which eligible persons would choose their own health care plan from among an array of private options. For example, beneficiaries might be able to opt for higher deductibles or coinsurance in exchange for coverage of services such as prescription drugs or long-term care. In addition, since many Medicare enrollees now supplement Medicare with private insurance, this approach would allow beneficiaries to combine the voucher with their own funds and buy one comprehensive plan. They no longer would have to worry about coordinating coverage between Medicare and their private supplemental plan. Moreover, persons with employer-provided supplemental coverage presumably could remain in the health care plans they had as employees.

Competition among plans to attract enrollees might help to lower prices, but it also seems likely that there would be considerable nonprice competition. As a consequence, the only certain way for Medicare to reduce costs under a voucher scheme would be to fix the payment level and its rate of growth over time (presumably with appropriate adjustments for risk).

To the government, this option offers the appeal of a predictable rate of growth. For example, the federal government could set the vouchers to grow at the same rate as that of gross domestic product (GDP) or some other factor. Most importantly, this option would achieve major cost savings. The “price” of offering choice to enrollees might be a voucher set at 90 or 95 percent of the current level of government spending per enrollee. Furthermore, by capping the rate of the benefit’s growth, vouchers shift the risk to the beneficiary if the cost of coverage exceeds the voucher amount.

If a plan is not successful in holding down health care costs and Medicare’s contribution is fixed, the most likely response would be to raise enrollees’ required supplemental contribution. This would effectively be an indirect premium increase on beneficiaries. Advocates of vouchers argue that consumer opposition to paying higher prices would force insurers to hold down costs and that the potential for higher costs therefore would be a good thing. Opponents claim that both consumers and insurers would lack the clout to achieve such cost controls.

How successful is the private sector likely to be in holding down costs, compared with the current Medicare program? First, private insurers almost surely will have higher administrative overhead costs than Medicare has.
Insurers will need to promote their plans. They will face a smaller risk pool that may require them to make more conservative decisions regarding reserves and other protections against losses over time. They will not have the advantage of Medicare’s scale and governmental authority in imposing steep provider price discounts. In addition, these plans are expected to return a profit to their shareholders. All of these factors will work against private companies’ performing better than Medicare.

On the other hand, private insurers may be able to develop effective new cost containment schemes. They may be able to adapt to changing circumstances more readily than the public sector can, and they would not be subject to political opposition. By combining coverage of services that Medicare now covers with coverage of other medical care such as preventive services, drugs, and long-term care, the private sector may be able to find better ways to package and deliver care. But with Medicare payments already at the low end of the scale, the real challenge will be whether the private sector can truly manage the care that beneficiaries use.

Regulation would be needed to require insurers to take all comers and to guard against adverse selection. The program is most likely to be problematic in this regard if it is voluntary. Also, adverse selection would be more likely if Medicare enrollees were free to supplement their vouchers to enhance their coverage. Insurers may consider persons with the most to spend on certain types of supplemental coverage to be the best risks.

The most serious potential problem with vouchers is that the market would begin to divide beneficiaries in ways that would put the most vulnerable—those in poor health and with modest incomes—at particular risk. If voucher programs or other types of specialized plans such as medical savings accounts (MSAs) skim off the healthier, wealthier beneficiaries, many Medicare enrollees who now have reasonable coverage for acute care costs, but who are the less desirable risks, would face much higher costs. The result could be a two-tier system of care in which families with modest incomes would be forced to choose less-desirable plans.

On balance, vouchers offer less in the way of guarantees of continued protection under Medicare. They are most appealing as a way to cur indirectly but substantially the federal government’s contributions through erosion of the comprehensiveness of coverage that the private sector offers. The burdens of making the tough choices and assuming the financial risks would be borne by beneficiaries. Further, the federal government’s role in influencing the course of our health care system would be substantially diminished. For some, this is a major advantage. But the history of Medicare is one in which the public sector has often played a positive role, first by insuring persons largely rejected by the private sector and then by leading the way in many cost containment efforts. The most troubling
aspect of this option is the likelihood that the principle of offering a universal benefit could be seriously undermined.

**Managed care plans.** Rather than creating vouchers that effectively put enrollees at risk, Medicare could move to a system of expanding the types of managed care plans that can participate in Medicare, and providing incentives for beneficiaries to join these plans. Medicare could continue to set standards for plan participation, set or negotiate capitated rates, and share some of the risks. Medicare beneficiaries now may enroll in qualified HMOs, but the more loosely organized PPOs and point-of-service plans are not available under the program.

In a well-managed, high-quality capitated system, patients receive better continuity of care. Patient records and information can readily be shared within the organization, and thus services are better coordinated. Physicians have no incentives to prescribe unnecessary tests or procedures because they add to the cost of care. They do, however, need to perform good diagnostic and preventive services to reduce use of the big-ticket items such as hospitalization.

It is important to look closely at how managed care may hold down the costs of care, particularly in relation to Medicare beneficiaries. The private sector has been seeking ways to hold down health care spending, particularly in comparison with traditional indemnity insurance plans, using essentially four types of tools: (1) lowering administrative costs, in part by streamlining management and minimizing paperwork; (2) paying doctors and other providers lower fees in exchange for promises of high patient volume; (3) directly managing patient care, for example, by setting strict rules on hospital length-of-stay, offering financial incentives and imposing penalties to control the use of tests and referrals to specialists, and requiring that patients use network providers or pay a large copayment if they go outside the system; and (4) marketing products so as to attract good risks—that is, persons who are less likely to be high users of health care services.\(^\text{11}\)

Managed care savings for Medicare beneficiaries may not be the same as those for private employees who are moved from generous indemnity plans into managed care, because Medicare already is a relatively low-cost plan. Even more important, advocates of the privatization of Medicare presume that growth rates can be lowered year after year, so we need to consider whether these savings are sustainable over a long period of time.

Administrative savings may prove problematic for Medicare. First, Medicare’s administrative costs are low compared with those of most managed care plans. Moreover, if private plans compete for Medicare business, their marketing and advertising costs will be substantial. For-profit HMOs on average have a 14 percent differential between their premiums and medical care outlays, split between profits and administrative costs.\(^\text{12}\) Start-up costs
for new entrants into this market and even for those adding Medicare patients to existing covered populations may be high as well. For example, who will pay for the reserves necessary to ensure that private plans are on sound financial footing? Adding five or ten million new insured lives in the private market will pose major capitalization needs. New plans thus are not likely to save a lot from administrative advantages compared with the traditional Medicare program, particularly in the early years.

Similarly, many managed care plans can be very attractive to private employers because of the discounts they receive from providers, which can result in lower premiums. Medicare, however, already has obtained discounts in the form of administered prices that are usually well below what private insurers pay, and even below what managed care plans pay. It will be difficult for private plans to drive a harder bargain than Medicare already has. The likely exception is in areas in which there is excess capacity and managed care plans are wringing out that excess capacity by forcing providers to bid against each other at rates well below costs. But some of these deep discounts likely cannot be sustained over time, and it is not clear whether this approach to eliminating excess capacity will result in closing the lowest-quality or least-needed hospitals and physician services.

One area in which managed care may be able to improve upon Medicare is in truly managing patient services. Private plans not only can provide closer oversight, but they also can be more arbitrary and prescriptive than a national public program like Medicare can be. This means that, particularly in some areas such as home health and hospital outpatient services, private plans could control the use of services more effectively than Medicare now does. Although Medicare certainly could do better under its current structure, private plans can exclude problematic providers or restrict their behavior in ways that Medicare is not able to do. However, although Medicare is limited by due process requirements and other legal restrictions, these restraints are not all bad. They help to guarantee access to the system to all patients and providers. Further, private contractors are not likely to be concerned about the impact on society of their behavior, while Medicare should and will be held accountable.

Older and disabled beneficiaries represent a unique patient type, and many managed care firms have not been eager to move into this market. Older patients with multiple health problems may need to see a specialist regularly, for example, when many managed care plans seek to limit such contacts as much as possible. Such cost containment strategies might be less cost-effective for the Medicare population, and thus other arrangements might be needed. It will take time for new entrants into this market to develop the expertise to deal effectively with this population.

Because performance varies widely among managed care plans, consum-
ers must be aggressive advocates for their own care. The barriers to care that HMOs and others establish to discourage overuse may be intimidating, particularly for the very old or frail. It may be easier for HMOs to establish barriers to the use of needed services than to manage care on a case-by-case basis. Further, the restrictions on choice implicit in such a system are viewed negatively by many Medicare beneficiaries.

Finally, health care costs for Medicare beneficiaries are very unevenly distributed. Some elderly persons enjoy good health and rarely use health care services. Others are seriously disabled and require extensive treatment. In 1993, 10 percent of Medicare beneficiaries accounted for 70 percent of outlays, or an average expenditure of $28,120 per person. This is contrasted with $1,340 per person for the 90 percent of Medicare beneficiaries with the lowest outlays. Understanding this variation is particularly important in any discussion of expanding capitated managed care coverage under Medicare. If capitation payments are not appropriately adjusted for health status, over- or underpayments can be quite serious. Plans can make a considerable profit at a capitated rate of $4,000 or even $3,000 if they can avoid enrolling those beneficiaries who are in the most costly 10 percent.

Building On Medicare’s Strengths

At present, too little attention is being focused on how to improve the functioning of the basic Medicare program, as opposed to departing radically from its basic structure. The goal should be to preserve genuine choice for all Medicare beneficiaries of type of health care delivery system while guaranteeing high-quality care at a reasonable cost to both beneficiaries and taxpayers. Fee-for-service care has the disadvantage of creating incentives for too much care at too high a cost; capitated managed care has the disadvantage of creating incentives for too little care of substandard quality. Providing a genuine informed choice of both options for beneficiaries may counter the harmful consequences of either one. Even if Medicare moves dramatically toward offering private plans, a fee-for-service component will likely remain for the foreseeable future.

Major issues for improving Medicare include (1) improving Medicare’s fee-for-service option; (2) expanding Medicare managed care choices while assuring quality; (3) minimizing the difficulties posed by risk selection; and (4) determining what financial contribution Medicare beneficiaries and taxpayers can reasonably be expected to make.

Improving the fee-for-service option. Medicare’s greatest strength as a social insurance program is the efficiency of its fee-for-service option. It has low administrative costs and low provider payment rates. It could be characterized as a PPO that takes any willing provider that meets quality
standards. Its hospital prospective payment system (PPS) has built-in incentives for shortening hospital stays and lowering the cost of hospital care. Its system of physician payment promotes primary care and penalizes increased use by pegging future price levels to performance in meeting spending targets. These payment systems have markedly slowed the growth in Medicare hospital and physician outlays since their introduction in 1983 and 1992, respectively. They are a largely unsung success story.

Where the fee-for-service option falls short is the adequacy of its benefit package, the difficulty of coordinating benefits with Medicaid and private supplemental coverage, and its lack of oversight in the use of some services. The first two problems create complexity and confusion among beneficiaries and providers. Consequently, Medicare restructuring options should include the following: (1) a merging of Medicare Part A and Part B to simplify financing and administration; (2) creation of two standardized Medicare benefit packages: the current package with a unified deductible and a ceiling on out-of-pocket costs, and a comprehensive package that covers current services with little or no cost sharing and prescription drugs; (3) beneficiaries who prefer the comprehensive benefit package would pay an additional premium to cover the differential cost; beneficiaries who prefer private supplemental coverage or who have retiree health benefits could select the basic benefit package; others who prefer the simplicity and/or premium of the comprehensive Medicare benefit package could elect it; and (4) federalization of Medicaid supplemental acute care coverage for Medicare beneficiaries; Medicare cost sharing and premiums for poor and near-poor Medicare beneficiaries would be financed from federal general revenues and administered jointly with Medicare.\textsuperscript{15}

Improving Medicare’s fee-for-service environment also requires attention to further cost containment activities, particularly its payment and oversight activities. In some cases, Medicare could adopt innovations from the private sector. Changes could include expansion of prospective payment methods to include all Medicare benefits, including consideration of spending targets that link future prices to performance in controlling outlays; use of sophisticated computer techniques for profiling use of services, thus identifying outliers and possible abuse; establishing and applying strict principles for appropriateness of care; and selective contracting of some services, building on the concept of centers of excellence.

Since home health and skilled nursing home services have been the most rapidly growing portion of Medicare, savings could be sought in this area. Prospective payment methods have worked remarkably well for physician and hospital services and should be developed for home health, skilled nursing facility services, outpatient hospital services, clinical laboratory services, and durable medical equipment.
Consider the example of home health services. Costs for such services are reimbursed up to a ceiling, but we do not know, for example, how long each visit lasts, how many separate services are provided at one time, or even how many services patients with various characteristics are receiving. The available data suggest that home health aide services provided by proprietary agencies are where much of the explosive growth is occurring. New standards and prospective payment or other reforms in payment policy are needed, and careful assessment of the provision of services through profiling of providers and beneficiaries is in order. It may be necessary to place specific limits on particular types of visits or for particular diagnoses. While a high copayment could be very expensive for the frailest elderly and disabled persons, a nominal payment per visit might be appropriate, at least for home health aide services. In sum, there is much that Medicare can and should do to improve its oversight of home health care services. But this would require considerable new administrative efforts, and perhaps even an increase in administrative costs.\(^{16}\)

Medicare also could adopt innovations from the private sector, such as high-cost case management, to generate efficiencies in the treatment of very expensive illnesses such as cancer, and perhaps in chronic care; and selective contracting with providers for particular types of services, particularly those for which outcomes improve when large numbers of procedures are provided at one center. Enforcement of appropriateness-of-care standards is now possible with sophisticated computer programs for profiling service use.\(^{17}\) Many of these techniques could be readily adopted by Medicare with some investment in the necessary tools and training.

**Expanding managed care options.** Medicare now permits federally qualified HMOs and state-accredited competitive health plans to enter into risk contracts. Plans may make a profit on their Medicare beneficiaries, but only to the extent to which they make a profit on non-Medicare enrollment. Additional savings must be returned to beneficiaries in the form of improved benefits, reduced cost sharing, or reduced premiums.

Currently, 9 percent of Medicare beneficiaries belong to HMOs. Surveys and focus groups indicate that more beneficiaries would be willing to join managed care plans if their current physicians belonged to such plans and if their out-of-pocket costs were lower than they now are under Medicare and any supplemental coverage.\(^{18}\) As managed care grows in the private market, more physicians will participate in such plans, and more beneficiaries would be able to enroll without changing their current physician arrangements.

Medicare could take several steps to expand its managed care options. It could include PPOs and point-of-service plans that meet quality and fiscal soundness standards and provide either the basic or comprehensive benefit package. It could inform Medicare beneficiaries of all managed care plan options.
options available in their geographic area, provide beneficiaries with information on which to base an informed choice, and have beneficiaries enroll annually in either Medicare’s fee-for-service option or a managed care option. Finally, Medicare could allow beneficiaries to receive all or a portion of the savings generated when they enroll in a managed care plan with premiums below those of Medicare’s fee-for-service option.

**Minimizing risk selection.** The primary problem with expanding Medicare’s managed care options is the potential for risk selection—healthier persons will enroll in managed care plans, while less healthy persons will elect the fee-for-service option. Given the extreme variability in health care spending among Medicare beneficiaries, there is great leeway for plans to select relatively healthier beneficiaries for whom capitated rates exceed true costs. If managed care plans succeed in attracting and retaining relatively healthier Medicare beneficiaries, Medicare will overpay for those who enroll in managed care plans, while continuing to pay the full cost of the sickest Medicare beneficiaries who are unattractive to managed care plans. Medicare HMOs can switch to a fee-for-service method of payment from a capitated risk contract if they experience adverse selection, or they can encourage sicker patients to return to Medicare’s fee-for-service system (since Medicare allows monthly disenrollment).

Several approaches may help to minimize adverse risk selection: (1) regulation of marketing, enrollment, and disenrollment practices with Medicare managing the enrollment process and providing standardized information on plan choices; (2) adopting quality standards to ensure that chronically or seriously ill patients get appropriate specialty care; and (3) requiring all managed care plans to enter into risk contracts and requiring health care providers to choose between participation in Medicare managed care plans and participation in the Medicare fee-for-service option.

The most fundamental way to eliminate risk selection is setting capitation rates to reflect the risk of enrolled populations. However, we do not do this well now, and there is as yet no consensus on how to solve this problem. The current method of paying HMOs for Medicare patients is seriously flawed. Thus, even if enrollment were to expand more markedly, it is unlikely that the program would save money. In fact, it might even cost the program money. A recent study found that the actual cost of serving Medicare beneficiaries who enroll in HMOs is 5.7 percent more than Medicare would have paid for these same beneficiaries had they been covered under Medicare’s fee-for-service option.19

There are several options that might improve the current system: setting a national capitation rate with geographic cost-of-practice adjustment, rather than the current complex procedure of basing capitation rates on fee-for-service costs in a given geographic area; setting the national capita-
tion rate at 90 percent of the fee-for-service rate, rather than 95 percent, based on the extent of risk selection that now seems to be occurring; excluding the allowance for graduate medical education and disproportionate-share payments from managed care capitation rates; limiting the profit on Medicare HMO enrollment to a fixed rate, such as 2 percent, rather than the profit on non-Medicare enrollment that is now allowed; adding health status measures or proxies to the current Medicare capitation formula, using the best techniques available; designing explicit capitation payment rates for selected prevalent chronic conditions; and dividing payments into a basic capitation rate for low-cost patients and a new payment system for high-cost or special-needs patients. For example, once a patient exceeded a cost threshold (such as $5,000 of health care expenses in a given year), the capitation rate would no longer apply; instead, Medicare could place these patients in a separate special-needs plan with case management. Given the uncertainties surrounding these and other options, demonstrations or gradual implementation seems appropriate.

**Financing options.** These improvements may not generate substantial savings over the long term. They represent program improvements and should be considered on their merits apart from their savings potential. Yet their extensive uncertainties make them an unreliable foundation on which to ensure the future fiscal soundness of Medicare. Thus, additional financing options need to be discussed.

There are two basic alternatives for financing Medicare benefit payments: direct beneficiary contributions and taxes. Ultimately, this is a public policy choice that the nation must make. There is no one right combination of financial responsibility between beneficiaries and government. Informed debate, however, can be enhanced by a complete identification of options and by careful analysis of their implications.

If beneficiaries are asked to pay more, some options would be more equitable than others. Consider cost-sharing changes. While cost sharing makes theoretical sense as a means for controlling the use of services, in practice it often results in less use of services mainly by low-income families. Higher cost sharing would likely have only an indirect effect on most Medicare beneficiaries because they often have additional supplemental insurance that would insulate them from the direct impact. In addition, Medicare coinsurance and deductibles represent a complicated collection of mismatched requirements, some of which could be increased and some of which should be decreased. For example, the Part A hospital deductible ($716 per spell of illness in 1995) is very high by any standards, while the annual Part B deductible ($100) is quite low. Hospital and skilled nursing coinsurance are also unreasonably high. It makes sense to rearrange this cost sharing along more rational lines, with perhaps a small net increase.
Medicare premiums could be increased, and this would be a reasonable way to require higher contributions if special efforts are made to protect low-income beneficiaries. In particular, the qualified Medicare beneficiary (QMB) and the specified low-income Medicare beneficiary (SLIMB) programs should be moved from Medicaid into Medicare. This would likely improve low program participation rates. In addition, the eligibility cutoffs could be raised if premiums go up to ensure that moderate-income families would not be hit too hard. Savings from a premium increase should be more than sufficient to both reduce federal spending and cover the QMB program. This is one of the more promising areas for higher beneficiary contributions.

An income-related portion of a premium increase also could be considered, but there are practical implementation problems that may render this a less desirable initial step. Implicitly, Part A already has an income-related premium via the taxation of Social Security benefits, a portion of which is dedicated to the Part A trust fund. This element could be retained rather than eliminated, as some have suggested. Other ways in which Medicare beneficiaries could be asked to contribute more include the full taxation of Social Security benefits, or forgoing a portion of cost-of-living increases in Social Security benefits.

It seems likely, however, that the fiscal soundness of Medicare can only be guaranteed as the baby-boom generation reaches retirement if the program’s tax base is improved. To be dynamically sound, payroll tax revenues need to be supplemented with other sources of revenues that grow with the aging of the population, such as premiums paid by beneficiaries, especially if income related. By merging Parts A and B, a single trust fund could be established to receive payroll taxes, premiums, and general revenue contributions. If the fiscal discipline that the HI trust fund helps to instill is viewed as desirable, general revenues could be limited to a fixed percentage of total revenues or a fixed rate of increase over time.

In the current political climate it is tempting to rule out tax increases, but the United States has among the lowest tax rates of any industrialized society, and opinion polls indicate strong support for preserving Medicare benefits. Some revenue options may make more sense in the context of broader reforms, such as coverage of uninsured persons and long-term care services. A value-added tax, for example, has high administrative costs and makes sense only if substantial revenues are to be generated.

One of the most basic long-term issues that must be considered is the extent to which the costs of retired persons are borne by current workers. By the year 2030 under current projections, there will be two covered workers for every Social Security beneficiary (the current proportion is 3.3 workers to one beneficiary). The cost of Social Security and Medicare per worker
could be staggering. The age for Social Security eligibility is gradually being increased to sixty-seven; Medicare could do the same. The difficulty, however, is that those who have retired involuntarily because of limited job opportunities or health reasons can take Social Security at age sixty-two, but at reduced actuarial rates. Medicare now has no such option, and many early retirees become uninsured and are at great risk.\textsuperscript{28} If the Medicare retirement age were increased, consideration would need to be given to permitting early retirees to purchase Medicare on a subsidized basis, particularly given the lack of access to individually purchased insurance.

**Conclusion**

What should be preserved is the essential role that Medicare plays in guaranteeing access to health care services and protecting beneficiaries from the financial hardship that inadequate insurance can generate for our nation’s most vulnerable elderly and disabled people. No American should become destitute because of uncovered medical bills, nor should anyone be denied access to essential health care services. Medicare is a model of success. It should not be hastily jettisoned in an ill-conceived and shortsighted effort to obtain federal budgetary savings. Instead, a full array of options needs to be carefully analyzed, critiqued, and debated.

*The views presented here are those of the authors and not necessarily those of the institutions with which they are affiliated.*

**NOTES**

2. Ibid.
7. Just as the 1983 amendments set into law changes in the age of retirement that do not even begin to take place until 2000, it is important to signal to younger Americans what they can expect from these programs in terms of level of support, age of retirement, and level of tax contributions, for example.


15. A voluntary long-term care insurance supplement financed by an income-related premium might be another option that could be considered as well. Davis and Rowland, Medicare Policy. Although offering two standardized Medicare benefit packages has considerable appeal to allow beneficiaries to opt for just one simple public program, there is the danger that sicker beneficiaries will opt for comprehensive benefits while healthier beneficiaries will select basic coverage. If so, premiums will need to be risk-adjusted—encountering the same methodological problems that managed care options create. Some limits on shifting between options might need to be imposed as well. See M. Moon, “Adding a Long Term Option to Medicare,” in A Call for Action, Supplement to the Final Report, The Pepper Commission (Washington: U.S. GPO, September 1990); D. Rowland and B. Lyons, Medicare’s Pour (Baltimore: Commonwealth Fund Commission on Elderly People Living Alone, 1987); and Moon and Mulvey, Entitlements and the Elderly.

16. Indeed, Medicare will find it difficult to adopt new techniques for improving oversight if administrative budgets are severely cut in the future.


20. J. Newhouse, Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance (Santa Monica, Calif.: The RAND Corporation, 1982).


22. Ibid. These programs are likely to be at considerable risk if Medicaid becomes a block grant or even if states are given more discretion concerning coverage and eligibility.

23. Davis and Rowland, Medicare Policy.


