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‘Rethinking Medicare Reform’
Needs Rethinking

Reformers cannot ignore marketplace realities in their quest for solutions to Medicare’s nagging problems.

by Henry J. Aaron and Robert D. Reischauer

Theodore Marmor and Jonathan Oberlander present a pastiche of the diagnoses that have led many health analysts to prescribe structural reform of Medicare (“Rethinking Medicare Reform”). They then criticize a caricature of the voucher cure and offer a structurally flawed and politically unviable alternative reform.

To the projected increases in health care costs as baby boomers retire, which Marmor and Oberlander belittle, should be added at least two additional reasons for reforming the structure of Medicare. First, Medicare’s benefits package is inadequate, and the prospects for improving it under the current program structure are poor. More than two-thirds of elderly beneficiaries feel the need to supplement Medicare coverage with Medigap insurance or an employer-sponsored retiree wraparound policy. Rapid increases in premiums for these plans are causing growing numbers of employers to drop or scale back retiree coverage, and the high costs of Medigap coverage are straining the limited budgets of growing numbers of seniors. Structural reform is one way of making a more comprehensive benefits package affordable.

Second, a chasm is opening up between the dominant forms of private health insurance and the structure of unmanaged fee-for-service Medicare. When enacted, Medicare resembled the Blue Cross and Blue Shield–type policy that employers typically purchased for workers and their families. This coverage consisted of two indemnity plans, one for hospital bills and the other for physician charges and medical services. Private insurance has changed since that time. The boundaries between hospital and physician coverage have broken down. Pure indemnity plans offering totally unmanaged care and an unlimited choice of providers are becoming extinct. Arguably, such insurance is a superior product, but, like the Betamax video system, it hasn’t been able to hack it in the marketplace. Soon public support may begin to erode for a system of coverage for the aged and disabled that is substantially different from and, therefore, more costly than the health plans that cover the average taxpayer’s family. In addition, if Medicare’s structure continues to diverge from that of plans covering the nonaged, non-disabled population, the administrative problems facing providers will become ever more complex, and the opportunities to game Medicare ever greater.

■ The voucher question. Marmor and Oberlander criticize one particular voucher plan. Actually, voucher proposals come in many forms. Their criticisms apply to only the least sophisticated ones. Of course, serious problems would arise if Medicare turned participants loose with vouchers of identical size to seek coverage in a loosely regulated private insurance market. If the value of the voucher increased less than medical costs for society as...
a whole, coverage surely would deteriorate.

But there are more sophisticated approaches.\(^2\) Plans operating in a carefully regulated marketplace could be required to offer a benefit package similar to that available to the typical worker. The size of the average voucher could be determined competitively—for example, set equal to the median bid submitted in each market area. Bids would rise at about the same pace as the costs of providing health care services to the population at large. Contrary to Marmor and Oberlander’s assertion, the financial impact of medical inflation need not be placed on beneficiaries. In addition, the vouchers could be adjusted for differences in participants’ risk, just as the Balanced Budget Act of 1997 requires of the capitated payments made to Medicare+Choice plans starting in 2000. These adjustments will undoubtedly be far from perfect, but workable mechanisms can be developed that eliminate much of the incentive to cherry-pick, and, over time, these tools can be improved. We acknowledge a risk to this approach: It may be easier to shave premium increases from a voucher plan than it is to cut benefits from a specified benefits package. If the current benefits package were not so deficient and the financial threat to even this meager system were not so serious, this criticism of vouchers might give us pause.

This does not presume that “Medicare beneficiaries should be moved into managed care plans,” as Marmor and Oberlander charge. In a competitive framework of this sort, as in the new Medicare+Choice component, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), and private fee-for-service (FFS) options can be offered in addition to more traditional managed care plans. Nor need a voucher system sacrifice Medicare’s commitment to universalism and segment beneficiaries across plans according to their ability to pay and their health status. If risk adjustment is adequate, if all plans are required to offer as one option a standard comprehensive benefits package without supplements, if limits are placed on the maximum premium that can be charged for these basic policies, and if supplementary vouchers, which would be the functional equivalent of specified low-income Medicare beneficiary (SLIMB) and qualified Medicare beneficiary (QMB) payments, are provided to low-income participants, universalism is preserved.\(^3\)

It is an error to exaggerate the current uniformity of Medicare. Medicare participants do not now enjoy “equal medical care coverage.” Some have supplementary insurance, while others do not. Actual benefits vary widely because the capitated payment amounts provided to Medicare health maintenance organizations (HMOs) in some areas allow them to provide rich packages of supplementary benefits, while in other areas the payment rates are so low that no capitated plans are available.

Analysts are attracted to the voucher approach not because they want to undermine the philosophical foundations of Medicare, but rather because they believe that this approach will promote efficiency, which can benefit participants, taxpayers, and the national economy. Under such a system, plans will compete to provide high-quality care at an affordable price. Plans will have a stronger incentive and a greater ability than Medicare to curb fraud, abuse, and services of marginal efficacy, while participants will enjoy more comprehensive coverage. None of this is to deny that a poorly constructed voucher structure could create a system far inferior to today’s Medicare. But that is an argument for doing the restructuring job well, not for avoiding structural reform altogether. Nor are improvements in efficiency alone likely to allow a restructured Medicare to live within the

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constraint set by current payroll tax rates. Some increase in payroll taxes is inevitable if adequate benefits are to be sustained.

■ The budget question. Marmor and Oberlander are certainly correct when they point out that there are other ways to curb the growth of Medicare costs. Their preferred approach is to establish an annual Medicare program budget that would be determined by legislation and regulation and enforced through sector-specific caps on physician, hospital, home health, and other spending. It is ironic that this structure is almost identical to that endorsed by congressional Republicans in the Balanced Budget Act of 1995, which President Clinton wisely vetoed. Such a structure would do little to change Medicare’s incentives in ways that could promote efficiency. It could create access problems, particularly where providers are not in excess supply. Moreover, as was correctly pointed out in the 1995 debate, this structure would make Medicare an even more bureaucratically rigid system.

Although such a structure could hold down costs, experience suggests that it would inhibit the spending shifts likely to emerge from advances in health technology. The essence of modern medicine is the emergence of new technologies that cause large, unpredictable shifts in outlays. Would regulators and politicians respond with sufficient flexibility? If such a system had existed over the past decade, would they have increased sectoral caps sufficiently to accommodate the shift to outpatient treatment that caused hospital occupancy to fall and outpatient outlays to skyrocket, or would inpatient hospital interests have lobbied successfully to maintain their share of the Medicare pie? Would regulators have allowed home health to absorb an increasing fraction of the resources devoted to postacute care, or would institutional care providers have protected their portion of the Medicare budget?

■ Facing reality. Marmor and Oberlander argue that the experience abroad proves the efficacy of their approach. Their analysis, however, ignores not only the recent drift of private market developments and political trends in the United States, but also a key difference between the situation abroad and that facing Medicare. Global budgets and sectoral spending caps work best when there is a single payer and universal coverage. Medicare is a substantial but minority payer, accounting for less than 30 percent of national spending on hospital and physician services. The forty-one million uninsured Americans attest to the absence of universal insurance. We explore the failure of efforts to assure universal coverage, as do Marmor and Oberlander. But regret cannot undo history. Managed care continues to grow in importance even though it has sometimes meant not only leaner, but decidedly meaner, health care. The world in which cross-subsidies could help to pay for health care for the uninsured is disappearing. Like it or not, these trends and developments are here to stay. In designing reforms to control Medicare’s costs and to make its coverage more adequate, we think it unwise and ineffective to proceed as if history had turned out differently than it did and as if obvious market trends did not exist.

NOTES


3. Under the QMB provisions, Medicaid pays the Part B premiums and cost-sharing amounts for Medicare beneficiaries with incomes below the federal poverty level. Under the SLMB provisions, Medicaid pays the Part B premiums for those with incomes between the poverty line and 120 percent of that level. In addition, a portion of current Medicaid expenditures on dual eligibles (those covered by both Medicaid and Medicare) are for services that would be included in an expanded Medicare benefits package.