Will The Care Be There? Vulnerable Beneficiaries And Medicare Reform

What the government can and should do to make sure that Medicare continues to cover those who most need coverage.

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ABSTRACT: The Medicare program is on the verge of major change. The proof of the value of reforms will not rest in how well the program meets the needs of the healthy and wealthy, but rather in whether they preserve or improve upon protections for those who would not be well served by an unregulated private sector—persons with low incomes and/or substantial health problems. This paper examines four key issues: Which beneficiaries will likely be best served by a system oriented around choice; what role traditional Medicare should continue to play and what changes will be needed; what protections are necessary for persons with low and moderate incomes; and how these reforms could be incorporated into broader changes to make Medicare more viable over time.

ONE OF MEDICARE’S GREATEST SUCEESSES has been its achievement of universal access to care for its beneficiaries. Consequently, in considering any proposal for changing Medicare, reformers should consider how well any changes would meet the needs of the most vulnerable beneficiaries. The goal of this paper is not to offer a fully developed proposal, but rather to bring into focus criteria that should be used in evaluating both the suggestions for change made here and proposals by others.

Despite considerable rhetoric to the contrary, many people remain vulnerable. The official 1998 poverty guidelines for eligibility for public programs are $8,050 for single persons and $10,850 for couples. Given the average of $2,600 in health care costs that individuals must bear over and above what Medicare and other insurers pay, that is surely too low a benchmark for vulnerability. Setting the level at 150 percent of poverty—about $12,000 for a single per-
son—would include ten million persons or 30 percent of all Medicare beneficiaries.

Also, many Medicare beneficiaries have substantial health problems. Nearly one-fifth of those in Medicare’s fee-for-service (FFS) program were in poor physical health in 1993. A total of 23.2 percent of beneficiaries listed problems with cognitive functioning, including mental retardation, mental disorder, Alzheimer’s disease, or difficulties in handling money or talking on the phone. Combined, 31.6 percent of all beneficiaries have one or both types of these impairments.²

But Medicare reform options also need to be assessed in the context of a broad set of goals. These should include assuring a stable source of high-quality care to elderly and disabled persons, assessing how excluded persons will get care if eligibility is limited, and ensuring that the program is designed and administered efficiently. Even the most efficient program will need resources to serve a doubling of Medicare’s population and a near doubling of the share of the U.S. population served by Medicare. Thus, as a final goal, the system to pay for such care should spread burdens fairly.

Recent Legislative Changes

The Medicare program, as modified in 1997 by the Balanced Budget Act (BBA), is likely to increasingly become two separate, and perhaps unequal, programs. The traditional FFS portion of Medicare will remain for the foreseeable future, still expected to serve about half of all beneficiaries in 2030.³ Because of the BBA, a substantial tightening of access to some services may occur, and in some cases, the program’s efficiency will improve. But the BBA also requires changes in treatment of home health and other services that some fear will go too far in limiting care for the vulnerable.

The second portion, the new Medicare+Choice or Part C, builds upon Medicare’s long-standing managed care option. A range of new private plans will be allowed, extending beyond traditional health maintenance organizations (HMOs). Some of these new plans may work to the disadvantage of vulnerable beneficiaries. These new plans are slated to start in January 1999, well before other reforms to establish protections for the vulnerable will be in place.

To protect the vulnerable, it is essential to have a private plan payment mechanism that adequately adjusts for the varying costs of beneficiaries who enroll. The current system is inadequate; consequently, plans face a strong incentive to discourage enrollment by persons with substantial health problems and to encourage those who develop problems to disenroll.⁴ The payoff to selecting less costly patients is now higher than the returns from efficiently man-
aging care for such patients. The BBA requires development of new
care payment adjusters, but no approach yet has satisfactorily resolved
this problem. Further, because a healthier mix of patients now
enrolls in private plans, plans are, on average, paid too generously.
Thus, Medicare loses money on each new enrollee.

The BBA also raises premiums across the board for Part B of
Medicare. For example, the basic monthly premium is expected to
be about $106 per month in 2008, $45 higher than the premium
projected before the BBA. For a beneficiary with an income of
$10,000 (which then grows at the rate of projected Social Security
benefits), this premium will nearly double as a share of income (to
more than 9 percent) by 2008.

Despite considerable rhetoric about further protecting low-
income beneficiaries, the BBA falls short. Modestly expanded pro-
tectives for low-income beneficiaries were included, but only
through 2002. Persons with incomes between 120 percent and 175
percent of poverty may receive protections, but the amount allo-
cated is insufficient to reach even a portion of eligible persons with
incomes between 120 percent and 135 percent of poverty.

Early assessments of Medicare reforms contained in the BBA in-
correctly downplayed the significance of the changes that have been
set in motion. The nature of the basic program is changing in critical
ways, and the jury is still out both on whether reforms will work as
planned and what their impact will be on the most vulnerable.

What Should The Future Hold?

Focusing on vulnerable beneficiaries in evaluating approaches to
reform suggests both needed changes and what options do not
stand up well to scrutiny. For example, if we care about those with
low incomes and substantial health problems, reforms should not
place too much emphasis on the “market.” Second, for the foresee-
able future it will be important to rely upon and strengthen tradi-
tional Medicare, including improving the basic benefits and adding
extra protection for low-income beneficiaries. Third, requirements
for greater beneficiary contributions need to be carefully targeted,
recognizing the diversity of the population. Finally, broad-based
financing to keep up with greater future needs will be required.

■ The clash between markets and vulnerable beneficiaries. Under
even the current setup, Medicare faces major problems in
making its private options work to the advantage of both taxpayers
(holding down costs) and beneficiaries (effectively meeting health
care needs). This suggests a go-slow approach. Yet voucher options,
requiring beneficiaries to choose among private plans and eliminat-
ing traditional Medicare, have been seriously proposed as a solution
to Medicare’s long-run problems. This would require thirty-three million beneficiaries to switch insurance arrangements.

What is the justification for adopting vouchers? Belief in the private sector’s ability to hold down costs of care is a primary motivator, reflecting a strongly held philosophical viewpoint, but not one backed up with facts. Since 1970 Medicare’s cumulative rate of cost growth has been lower than that of private insurance, even including the 1990s, when the successes of private plans have been strongly touted. Medicare has been more successful while retaining a mainly FFS system and absorbing large numbers of new beneficiaries.

Can we expect the private insurance market to do better than Medicare at controlling health care costs in the future? Competition among private plans does not magically lead to lower costs. It is what plans do that matters, and as the current disaffection with managed care for the younger population demonstrates, many techniques now used by private insurers are viewed with hostility for emphasizing the management of costs rather than managing care. Over time, progressive plans may be able to improve techniques for managing care effectively, thereby establishing a case for further privatization, but the evidence does not yet support a full restructuring of Medicare. Voucher approaches mean that if private plans are unable to hold the line on health care costs, beneficiaries would face the dilemma of choosing less care or supplementing Medicare’s payment. Ultimately, vouchers are ways of shifting both risk and financing to beneficiaries.

What are the benefits of a market-oriented approach? Giving beneficiaries more flexibility would allow choice between less expensive but more restrictive plans and plans offering more freedom at higher cost. But this tradeoff would be limited to beneficiaries with income levels sufficient to afford reasonable choices. One likely outcome is different plans for rich and poor, splitting up beneficiaries in a way that Medicare thus far has successfully avoided. Moreover, allowing plans to offer differing packages of benefits may exacerbate risk-selection problems. Until mechanisms for establishing premiums can be greatly improved, few plans are likely to actively recruit people with health problems. How many health plan advertisements feature seniors in wheelchairs or hospital beds instead of playing golf or tennis?

“It is unlikely that Medicare can or should turn back the clock and eliminate private-plan options.”
It is unlikely that Medicare can or should turn back the clock and eliminate private-plan options. Rather, time is needed to improve their performance and to allow plans to demonstrate that they can save money while meeting beneficiaries’ needs. Development of new payment mechanisms and further work on improving risk adjusters, for example, constitute steps necessary before considering more privatization. Of necessity, a public program cannot quickly change to undo mistakes, so before making substantial changes in Medicare, it is critical to identify and verify private market successes. Not all private-sector changes represent improvements, and Medicare should proceed cautiously.

**Working with the traditional Medicare benefit.** The most important challenges facing Medicare are to make the two pieces of the program work together and to improve traditional Medicare. These efforts are less dramatic than a full-fledged overhaul, but, at least for some period of time, traditional Medicare should remain in place to meet the needs of the most vulnerable.

Better oversight is essential, to ensure efficiency, accountability, and quality in the provision of care, and traditional Medicare needs reform to make it a more viable competitor. Although the BBA sometimes has been dismissed as minor tinkering, it lowered Medicare’s projected share of the gross domestic product (GDP) (net of the Part B premium) in 2020 from 5.44 percent to 4.08 percent. Since many BBA provisions expire after 2002, there is room for further savings if some of these provisions are extended. Only time will tell if Medicare’s FFS portion can continue to adopt policies to assure efficient operation and quality of service. Greater adaptability to innovation could help to mitigate the well-known problems of FFS medicine.

Given a choice, the sickest and poorest beneficiaries are likely to disproportionately remain in traditional Medicare, creating substantial challenges for this part of the program. Nearly one-third of those likely to remain in the FFS system have substantial physical or cognitive problems. Such persons account for more than half of the spending of persons in traditional Medicare. A second group less likely to consider switching out of traditional Medicare is persons age eighty-five and older. Adding such persons who are not already in the medically impaired group raises the share of those less likely to enroll in private plans to 37.4 percent of beneficiaries. (This group, however, may constitute a transition population that is more willing to join private plans in the future.)

A third group is those with Medicaid coverage. Since Medicaid fills in the gaps in Medicare for low-income persons, it may take away a major selling point of private plans. Moreover, in many states Medicaid now will not pay private plan premiums.
group brings the total share of beneficiaries unlikely to enroll in private plans to 43.3 percent, and expenses to nearly two-thirds of the total.

**Benefit improvements.** One of the most difficult and essential pieces of reform is expansion of Medicare’s basic benefit package. Private supplemental (Medigap) plans are becoming unaffordable for beneficiaries with average incomes. Costs of policies rise rapidly as the risk pool becomes more heavily weighted with beneficiaries with health problems.\textsuperscript{13} Moreover, plans have moved away from community-rated premiums to arrangements in which premiums rise dramatically with age. Consequently, these experience-rated Medigap plans shift costs onto those beneficiaries least able to absorb them. Further, efficiencies could be gained from having beneficiaries rely on only one plan.

A more rational Medicare cost-sharing package would not have to be extraordinarily expensive, especially if it increased cost-sharing in areas such as the Part B deductible that are likely too low now, while reducing the unusually high hospital deductible and adding stop-loss protection.\textsuperscript{14} In addition, the other most crucial element for a more up-to-date benefit package is a prescription drug benefit. Those purchasing Medigap plans can at best obtain limited prescription drug protection (and increasingly many private managed care plans also restrict these benefits). Drugs are viewed as an essential part of today’s health care treatments. But they also represent a particularly strong way to select on risks; private plans that offer prescription drug benefits find that they attract sicker patients.\textsuperscript{15} Thus, to assure future availability, prescription drugs are a crucial piece of an expanded benefit package.

Expanded benefits could be coupled with increased premiums, likely resulting in lower net costs than the current combination of Medicare and Medigap premiums. A key question, however, is whether to make an expansion voluntary or mandatory. A voluntary program is likely to attract higher-risk beneficiaries, causing the problems noted above. An intermediate approach would create a two-tier premium: a mandatory premium based on Medicare’s current Part B premium, and an optional premium covering expanded benefits. The mandatory premium could be considerably higher than today’s Part B premium to help subsidize the voluntary benefits. In the same way that the current voluntary Part B premium attracts beneficiaries because it is a good deal, participation in a subsidized, expanded-benefits option should be less subject to risk selection. Persons with employer-provided retiree insurance—who might object to higher premiums for increased benefits—could opt out of the voluntary portion.
Low-income protections. Higher beneficiary premiums would make it even more important to find ways to expand low-income protections, moving the current inadequate Qualified Medicare Beneficiary and related programs from Medicaid to Medicare and raising the income and asset eligibility cutoffs. Putting these protections under Medicare would likely help to increase the current low participation in these programs.\(^\text{16}\) Raising the income and asset cutoff levels would make it more feasible to raise premiums without unduly burdening those with the lowest incomes. Further, if Medicare were to adopt a two-tier premium structure, persons with the lowest incomes could receive full premium protections, while those higher up the income scale could receive a subsidy for only the required premium. This would phase out protections more gradually than the current system does.

Universality versus eligibility changes. One “solution” often proposed for the greater numbers of persons turning age sixty-five after 2010 is to find other ways to limit eligibility for Medicare. However, there is value in sustaining a universal program: Not only is it more efficient to oversee and administer than is, for example, a means-tested program, but universality helps to ensure that the most vulnerable are considered “mainstream.” Universality also carries political advantages. Finally, any proposal to limit eligibility should be required to indicate how the excluded will get care.

One possible change in eligibility would be to fully means-test Medicare, making it available only to persons with resources below some threshold. Higher-income elderly and disabled persons could be offered the option of buying into the system at a nonsubsidized rate or precluded from participating. For a number of practical reasons, keeping the program universal but modifying the level of the Medicare subsidy (described below) is a more feasible approach.

Raising the age of eligibility for Medicare is another proposal offered to reduce the size of the beneficiary population. Life expectancy has increased by about three years since Medicare’s passage in 1965, which offers one justification for delaying eligibility.\(^\text{17}\) Moreover, if actual retirement ages rise, this option becomes more viable.

This approach also has disadvantages. Without private insurance reform, persons who are out of the labor force might find it difficult to obtain insurance; again, a buy-in to Medicare at reasonable actuarial levels would likely be needed. Some employers, faced with potentially higher insurance costs, might cut back on retiree benefits. As a consequence, if the number of uninsured persons rise and thereby place greater burdens on public hospitals, if the costs of producing goods and services rise to pay greater retiree health benefits, and if the number of young families supporting their older
relatives increases, we will be just as burdened. Thus, we would not have solved anything, although the balance on the federal government’s ledgers would improve.

Finally, each age group of the population contains a substantial share of vulnerable beneficiaries who would need special protections, since they are less likely to be served by the private market; but protections would lower public savings.\footnote{18} If public financing of Medicare becomes a major problem, age of eligibility may be a piece of a final reform package; its acceptability depends on what other adjustments are made to protect those excluded from Medicare.

\textbf{Increasing costs on beneficiaries directly.} Some piece of a long-term solution will (and likely should) include increases in contributions from beneficiaries beyond what is in the BBA. The question is how to do this fairly. Passing more costs of the program onto beneficiaries needs to be carefully balanced against beneficiaries’ ability to absorb these changes (and assessed against other policy changes such as in Social Security).

The easiest way to raise additional revenues from beneficiaries is through an across-the-board increase in the Part B premium. Small increases generate large amounts of resources, although increases added by the BBA mean that Medicare beneficiaries will be paying about 12 percent of the total costs of the program by 2008, up from 9 percent in 1998. A higher premium would likely be more acceptable if it were combined with an improvement in Medicare benefits (as discussed above).

An alternative, subtle means of shifting the burden to individuals—but often not scrutinized in the same way—is through a voucher system. If the voucher were constrained to grow at a fixed rate over time, it could generate a regressive impact as low- and moderate-income beneficiaries found it difficult to obtain reasonably priced insurance for the voucher amount. Further, eliminating government’s stake in health care costs would mean one less player concerned about reducing those costs over time.

Another option is an income-related premium, whereby higher-income persons would pay a greater share of Medicare’s costs. Tying premiums to income makes sense on grounds of equity but may be difficult to achieve in practice. Administrative costs would rise substantially. More important, such approaches generate only limited new revenues unless the income thresholds are set very low. For example, the income-related premium proposed by the Senate in the BBA (but not included in the final legislation) was estimated to raise just $1 billion over the period 1998–2002.\footnote{19} There simply are not enough high-income elderly persons for this option to “solve” the problem.
An alternative income-related approach would treat Medicare benefits—all or in part—as income and subject to the federal personal income tax. This is analogous to taxing Social Security, although more complicated because these benefits are received “in-kind” and are not traditionally viewed as income. Taxation of benefits not only would raise revenue but also would make beneficiaries more aware of the “value” of Medicare benefits. However, this option would add considerably to Medicare’s complexity, and critics argue that it is unfair to tax some in-kind benefits and not others. Adopting either such taxation or an income-related premium may be justified as a symbolic gesture as part of the solution for Medicare’s financing problems.

**Additional public financing for Medicare.** Ultimately, the issue of who will pay must be divided between beneficiaries and taxpayers. Even with beneficiary contributions, the long-run costs of Medicare will require additional public funds. As the number of beneficiaries grows from 14 percent of the population in 1997 to 22 percent in 2030, it is appropriate for Medicare’s share of both GDP and the federal budget to rise.\(^2\) The share of the population getting insurance from other sources will fall, at least partially offsetting higher costs to Medicare over time—a fact often ignored by Medicare’s critics.\(^2\)

The payroll tax share for Medicare Part A at 2.9 percent of earnings (reflecting the combined employer and employee amounts) has not risen since 1986.\(^2\) If the percentage of payroll devoted to Medicare were increased by a factor just to account for growth in the share of Americans covered by Medicare, the combined tax rate should be 4.2 percent by 2020. But for Part A, for example, rate increases could be lower for some time to come. The Medicare actuaries have estimated that a one-percentage-point tax increase (bringing the combined total to 3.9 percent of payroll) would be enough to extend the life of the trust fund to 2030.\(^2\) With reasonable restraints on spending and other policy changes as described above, such a tax increase would keep the program in balance even longer. Revenues for Part B also will have to be increased, through general revenues or perhaps new dedicated taxes. Although painful, these changes are of an order of magnitude that taxpayers might accept as the price of keeping the Medicare program intact for the foreseeable future.
It has become so fashionable to criticize Medicare as an out-of-control, out-of-date government program that “insider” policy analysts now accept as inevitable major structural changes in the program. The new mantra is that Medicare is unsustainable. But much of what people take as articles of faith—that the private insurance market performs better than Medicare, that beneficiaries are clamoring for choices among competing health plans, and that we cannot afford an aging society—do not hold up well to scrutiny. Medicare cannot and should not remain as it was in 1966 or 1996, but reforms need to take place in the context of broader health system change—and only after careful assessment of the costs and benefits of new strategies.

NOTES


2. Author’s simulations from the 1993 Medicare Current Beneficiary Survey.


12. Evidence from the Medicare Current Beneficiary Survey indicates that this is certainly true under the current private plan option arrangements. See also Medicare Payment Advisory Commission, Report to the Congress: Context for a Changing Medicare Program (Washington: U.S. GPO, June 1998).


14. M. Moon, Restructuring Medicare’s Cost Sharing, Report prepared for the Com-

15. Not only are private plans cutting back on drug coverage, but Medigap plans are being priced out of reach if they include drugs. See L.A. McCormack et al., “The Medigap Reform Legislation of 1990: Have the Objectives Been Met?” Health Care Financing Review (Fall 1996): 157–174.


