First Do No Harm: Why Vouchers are Bad Medicine for Medicare

by

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Introduction

For more than 35 years, Medicare has been the cornerstone of the nation's efforts to maintain the health and economic security of the elderly. By almost any measure, Medicare is a great success story. Before Medicare, half the elderly were uninsured and at risk of impoverishment due to medical care costs. Today, nearly all of the elderly are covered, and few fall into poverty due to medical expenses. But Medicare also faces a number of important challenges. Medicare's benefit package has not been updated to reflect changes in medical practice, providing far less comprehensive coverage than that provided by the private insurance plans held by the nonelderly, and leaving the elderly with large out-of-pocket spending burdens. With projections that Medicare will absorb a growing share of both the federal budget and the nation's economy with the aging of the baby boom generation, many have called for fundamental reforms to contain Medicare's growth. However, there is little evidence that the proposed structural reforms will work in practice; in fact, plenty of evidence exists that traditional incremental approaches can do the job. This issue brief provides an overview of the Medicare program, its successes and hurdles, and provides a critical appraisal of "premium support" (vouchers)—the leading proposal for Medicare reform.

The Basics of Medicare

Medicare is the world's largest single health insurance program, covering 39 million enrollees, including 98% of Americans over age 65 and 5 million younger persons who qualify as recipients of Social Security Disability Income. Between 1967 and 2000, Medicare spending grew from $3.3 to $222 billion, with average expenditures of approximately $5,500 per elderly beneficiary, significantly more than the average amount that is spent on health care for persons under age 65. At the same time, the average annual growth in real (inflation-adjusted) Medicare

expenditures per enrollee have shown a consistent downward trend over time, dropping from 11.2% per year in 1975-80, to 1.8% per year in 1995-1999 (Bodenheimer, 2002). This success in controlling overall federal expenditures on Medicare is often overlooked.

Medicare is really two programs, commonly referred to as Part A and Part B. Medicare Part A, also known as Hospital Insurance, covers payments for inpatient hospital care, skilled nursing facility care, home health services, and hospice care. Eligibility for Part A is automatic for Social Security and Railroad Retirement beneficiaries. Medicare Part B, Supplementary Medical Insurance, provides coverage for physician, outpatient, and laboratory services, durable medical equipment, flu vaccinations, drugs that cannot be self-administered, medical supplies, diagnostic tests, ambulance services, and some therapeutic services. A monthly Part B premium of $50 is required and is deducted directly from Social Security checks. Some of the poor and low-income elderly receive assistance from Medicaid, the nation's health care program for the poor, in paying Medicare premiums and cost-sharing.

A new Medicare Part C, the Medicare+Choice (M+C) program, allows beneficiaries to choose to enroll in health maintenance organizations (HMOs). By enrolling in these plans, the elderly in Medicare typically receive more comprehensive services than those provided in fee-for-service Medicare, including prescription drug coverage. Medicare+Choice has been plagued with difficulties, however. The number of beneficiaries enrolled in managed care plans has declined in the past few years, falling from 6.3 million enrollees in 1999 to 5.6 million in 2001. HMOs have withdrawn from the program in large numbers; at the same time, the remaining plans are reducing benefits and raising premiums and cost-sharing requirements. The number of M+C plans offering prescription drug coverage dropped from 73% in 1999 to 65% in 2001, and

the percent of zero-premium plans (those that do not charge any additional premium to enrollees) declined from 70% in 1998 to 46% in 2001 (Achman and Gold, 2002)

Medicare Part A and Part B receive funding from two different sources. Part A is financed by the American workers who pay a tax of 1.45% of gross pay, which is matched by their employers at the same rate. These revenues go into an interest-bearing trust fund that then pays out the benefits for this part of the program. Much of the political debate about the need to contain Medicare costs is motivated by the presumed financial crisis facing Medicare. In fact, only a few years ago, the need to contain costs was given particular urgency by projections that the Medicare Health Insurance (HI) Trust Fund would be depleted in 2001. It is worth noting that these projections proved to be completely inaccurate, since the economy grew at a faster rate in the 1990s than any of the official forecasts projected. Tremendous economic prosperity and the resulting growth in Medicare revenues, in addition to reductions in outlays due to successful cost containment efforts, have put the HI trust fund in its best short-range financial position in many years. The most recent actuarial projections suggest that revenues will be sufficient to cover expenses through 2029 (Annual Report, GPO, 2001).

Part B is financed partly from the income of beneficiaries, who pay a monthly premium, and partly through general federal revenues, primarily income taxes. Beneficiary payments cover 25% of the costs of financing Part B, the other 75% comes from general federal revenues.

Medicare's Successes

Medicare has substantially improved access to health care, and the health and financial security of the elderly. Prior to the enactment of Medicare, nearly half the elderly lacked health insurance coverage, and, although they were much more likely to be in poor health, the elderly population was much less likely than the nonelderly to see a physician or to be hospitalized.

Medicare dramatically improved access to medical care for the elderly, and the results have been remarkable. Medicare's impact on the health and well-being of the elderly is evident in dramatic increases in life expectancy among the elderly, and even more remarkable improvements in their functional status. In the 35 years since Medicare was implemented, life expectancy at age 65 has increased by more than it did in the 60 years before Medicare. And although life expectancy at age 65 is lower in the U.S. than in many other industrialized countries, the U.S. ranks higher in life expectancy at age 80, the age at which medical care is most important in extending longevity (Manton and Vaupel, 1995). Improved access to medical care has also contributed to the remarkable decline in age-specific disability rates. Just as access to medical care has increased life expectancy, it has also made people in their 70s and 80s healthier, with improvements in the treatment of hip fractures, osteoporosis, circulatory disorders, diabetes, and other diseases reducing the prevalence of disability and dependency among the elderly.

Another measure of Medicare's success is beneficiaries' satisfaction with their health care. "Surveys indicate that approximately 90% of Medicare enrollees are somewhat or very satisfied with their coverage. This compares with satisfaction rates in the range of 50 to 60% among persons who have private health insurance" (Vladeck, 2001). Medicare also helps to assure the financial security of the elderly. Since the enactment of Medicare and the indexing of Social Security benefits, the proportion of the elderly who live in poverty has fallen to a level below that of younger age groups. At the same time, the average income of a Medicare beneficiary who lives alone is about $13,000 (or about 150% of the federal poverty level). This means that the great majority of Medicare beneficiaries are lifted out of poverty *because* they have Medicare (Vladeck, 1998). Without it, (subtract the $5,500 in annual Medicare

expenditures from income), many of the elderly would be impoverished by their medical expenses.

Medicare's Problems

Medicare faces two difficulties: serving the aging baby boom population and expanding the limited scope of coverage. Between 2010-2030 (when the last of the baby boomers reaches age 65), the number of Medicare beneficiaries will nearly double, rising from 39 million to 77 million (from 12% to 22% of the U.S. population). With the growth in the number of enrollees, Medicare costs are projected to at least double.

The second difficulty is that Medicare provides broad, but nevertheless restrictive coverage to its beneficiaries. Covering only about half the medical care costs of the elderly, Medicare does not pay for a number of important services, including vision and dental care, most long-term care services, and most outpatient prescription drugs. Medicare cost-sharing is also high, with those who are sickest bearing the heaviest burden. Average out-of-pocket spending for elderly beneficiaries is $3,142 per person; in particular, for low-income women over age 85 who are in poor health, average out-of-pocket spending is $5,969 (Maxwell, Moon, and Segal, 2001). Because Medicare alone is not sufficient to cover the health care costs of the elderly, most need supplemental insurance. Despite its high price tag, most choose to carry it. About a quarter purchase individual Medigap coverage, 30% have insurance provided as a retirement benefit by former employer (although this number is dropping rapidly) 15% are enrolled in HMOs, and 12% have incomes low enough that they qualify for assistance from Medicaid. Medicaid pays Medicare Part B premiums and co-insurance for about half of these low-income beneficiaries; the rest receive full benefits through Medicaid, including prescription drugs and long-term care. Unfortunately, 10% of Medicare beneficiaries have no supplemental insurance

and are covered by Medicare only, generally those with incomes too low to afford individual Medigap and too high to qualify for Medicaid (Maxwell, Moon, and Storeyard, 2001). The result is very high out-of-pocket burdens especially for those who are sick: the elderly in poor health with no supplemental coverage have average out-of-pocket spending of $4,478 per person (Maxwell, Moon and Segal, 2001).

Lack of coverage for prescription drugs in Medicare is an especially important gap. Although two-thirds of Medicare beneficiaries have at least some drug coverage, that coverage has been both expensive and increasingly unstable (Laschober, Kitchman, Neumann, and Strabic, 2002). The 38% of beneficiaries without coverage for prescription drugs must pay the full costs out-of-pocket, costs that are increasingly burdensome since prescription drug prices have increased far more rapidly than the prices of most other things (including other health care expenses), and far more rapidly than the incomes of the elderly.

"Fixing" Medicare?

Medicare's rising costs and outdated benefit package have put Medicare "reform" firmly on the political agenda. Despite the tremendous economic boom that substantially improved Medicare's financial status, Medicare's long-term financial difficulties are said to remain. Large projected budget surpluses presented an opportunity to restore long-term solvency to the program, but that opportunity was lost, with half of the projected ten-year (2001-2010) surplus going to a large tax cut (Kogan, 2001). To address the projected funding shortfalls, several options for Medicare reform have been proposed, including cutting payments to providers and shifting costs to beneficiaries, but fundamental restructuring of Medicare through "premium support" dominates the political debate.

Premium support would convert Medicare into a "choice-based" system, one that would allow beneficiaries to choose from among a wide array of insurance arrangements and that would, at least in theory, create financial incentives for efficient choice, reducing the overall growth rate of Medicare costs. Premium support would require private plans to submit annual bids to supply the existing Medicare benefit package and possibly some additional benefits. An average bid for the participating HMOs would be calculated, and the voucher amount (the government's contribution) cover a share of this average price. Most likely, the voucher would cover most but not all of the cost of enrolling in the average-priced health plan, with the remainder of the premium cost picked up by the beneficiary. The out-of-pocket cost to beneficiaries would depend on whether they chose a relatively low cost, average cost, or high cost plan.

Today, Medicare guarantees beneficiaries access to a particular plan (the Medicare benefit package). Under a premium support or voucher approach, beneficiaries would instead be guaranteed a certain amount of money with which to purchase health insurance. Beneficiaries would also be at risk for cost increases in excess of the approved voucher amounts. Although beneficiaries currently have a choice between traditional Medicare and Medicare+Choice plans, premium support proposals typically call for an open-enrollment period during which beneficiaries would select a health insurance plan. In theory, this process would encourage beneficiaries to select lower cost health plans over time, driving down the growth of Medicare costs.

The theory underlying premium support is that HMOs can limit unnecessary spending on medical care, and that creating a mechanism for choice will restrain the growth of Medicare costs. However, the evidence is overwhelming that private plans have not saved any money for

Medicare. Rather, costs to the Medicare program are 5-7% higher for each beneficiary enrolled in a Medicare HMO. The reason is that Medicare pays HMOs 95% of the average per capita cost of a beneficiary enrolled in fee-for-service Medicare, but managed care enrollees are, on average, healthier and use fewer health care services than beneficiaries in fee-for-service.

Moving to a premium support would have profound implications for Medicare and its beneficiaries. If premium support were implemented, the quality of care for lower-income Medicare beneficiaries is likely to fall precipitously. Under a voucher program, the government would pay a certain amount each year to assist Medicare beneficiaries in purchasing health care coverage, and beneficiaries would have to pay the remainder of the premium out of pocket. As a result, those who could afford more expensive, higher-quality coverage would generally purchase it. Lower-income beneficiaries would be able to afford only the lowest-cost plans, which would probably be lacking in quality and access.

Whether premium support can achieve the result reformers hope to see depends on whether a number of practical issues can be resolved, including risk adjustment of premiums, accounting for geographic variation in costs, methods of preventing "gaming" in the bidding process, assuring quality in participating plans, and protecting low-income beneficiaries and those in poor health. And since premium support has never been tested, no one knows whether these practical problems can be resolved, or whether it would save any money at all (Vladeck, 1999).

Conclusion

Medicare spending, like all health care spending, will rise substantially in the future. But Medicare's short-term crisis has disappeared, and there is reason to question whether there is a long-term crisis at all. Economic growth will continue to make Medicare affordable, and a more

affluent nation may well decide to spend a growing share of its resources on medical care. Moving to premium support would mark a radical departure from the way Medicare currently works, and would create a number of risks for beneficiaries—especially the sickest and the poorest. Without a financial "crisis" in Medicare, and with little evidence to suggest that the proposed reforms would work in practice the way reformers hope they do, there is no reason to proceed with major structural reform. This is not to say that Medicare does not face any real problems. Certainly, Medicare's benefit structure will become increasingly inadequate unless major changes are made, and Medicare's current sources of financing will become increasingly inadequate. However, the problems that Medicare was designed to address are not going to go away, so the real question is how much additional revenue will be needed to preserve Medicare's current and existing benefits in light of rising costs of medical care and demographic change.

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