

ECONOMIC COMMENTARY

Federal Reserve Bank of Cleveland

Medicare: Usual and Customary Remedies Will No Longer Work

by Jagadeesh Gokhale

Medicare was established in 1965 to ensure that all elderly Americans have access to quality health care. After Social Security, the Medicare program—which covers almost everyone over the age of 65—constitutes the most important source of economic security for retirees.¹ Without its benefits, many of the nation's elderly would find it difficult to pay their medical bills and still maintain more than a minimum standard of living.

Medicare's own financial projections show that under current tax and spending rules, the program will be insolvent by 2001 (see figure 1).² The reason is burgeoning health care costs. In the coming years, the government will be forced to devote a growing share of the federal budget to providing medical coverage for the millions of seniors who have been promised Medicare benefits. The strain on both the nation's health care resources and the budget will become especially severe when the baby boomers begin to retire in just over a decade. Then, maintaining Medicare's current financing structure and benefit rules will mean imposing back-breaking payroll taxes on younger and future generations.

The recent balanced-budget agreement between Congress and the administration would slash Medicare growth by \$115 billion over the next five years, extending the program's solvency until 2007.³ Unfortunately, most of the cuts would come from additional cost-control measures, which could harm the quality of care provided to the elderly. The structural shortcomings that have promoted overconsumption in the health care industry and that have spawned Medicare's long-term financial woes are left untouched.

This *Economic Commentary* describes the structural deficiencies that have led to Medicare's impending bankruptcy and discusses the merits of alternative approaches to extending the program's long-term viability.⁴ When all the evidence is weighed, I argue that the best solution may be the "defined contribution" approach, which would induce beneficiaries to economize on spending by requiring them to pay the last dollar of their health care coverage. Consumers' greater cost consciousness in making marginal health care decisions is likely to translate into more competition among medical providers and insurers. Better incentives for both beneficiaries and caregivers should reduce the growth in health care prices in general and Medicare outlays in particular.

Medicare is projected to be insolvent by the year 2001. The budget for fiscal year 1998 pushes that date ahead a few years by introducing additional cost-control measures, but it will not rectify the structural deficiencies associated with the current system. Moreover, it is likely to worsen the quality of care for Medicare enrollees. A better approach—one that will help solve Medicare's problems in the long run—is to adopt a "defined contribution" plan that will restore consumers' interest in economizing on health care services and boost competition among providers and insurers.

■ Onset of the Problem

In 1983, Congress revised the Social Security system to restore solvency over a 75-year horizon. Unfortunately, no such effort was undertaken for Medicare.

Since its inception in 1965, Medicare's financing problems have been addressed by repeatedly extending the program's viability for a few more years, mainly through increased payroll taxes.

In part, this policy was dictated by the difficulty of projecting total Medicare outlays over long horizons. Future outlays depend on the prices, volume, and intensity of demand for covered medical services, all of which are influenced by market forces, technological advances, and demographic changes that lie outside lawmakers' control.

Since the early 1980s, health care prices have risen much faster than the general price level, as measured by the Consumer Price Index (see figure 2). Real per capita spending on medical services has also soared, a sign that more services are being used more intensively. The increase in both the price and the volume of medical care indicates that growth in demand has outpaced the health care sector's ability to supply the required services.

The escalation of health care prices and per capita spending can be traced to several sources. First, providers are paid not by consumers directly, but by third parties — private insurers, Medicare, and Medicaid. This system substantially reduces both providers' and consumers' incentives to conserve on their use of health care resources.⁵ Second, although technologically sophisticated treatments have improved the quality of care and may have enhanced the efficiency with which that care is delivered, they have also increased the "resource intensity" of medical services; that is, curing particular illnesses now involves more expensive equipment and skills than in the past. Third, employer-purchased health insurance is tax-subsidized. This induces employers to buy more generous health

insurance plans than they would otherwise, increasing the demand for health care resources. Fourth, the widespread practice of defensive medicine to safeguard against malpractice suits uses resources to deliver services that may be, medically speaking, unnecessary.⁶

Medicare is not insulated from the effects of market and technological developments in the health care sector. This is because, in the interest of maintaining access to high-quality care for the elderly, Medicare does not proscribe the use of expensive treatments and procedures, nor does it limit the amount of service rendered during particular bouts of illness. Hence, the cost- and volume-augmenting features of our current health care system have led to rapidly mounting Medicare outlays. Despite attempts to control per unit costs in some types of covered services, Medicare enrollees' real per capita spending on health care has increased.⁷ In fact, it has expanded more rapidly than for the total U.S. population (see figure 3).

■ Cost-Control Remedies

An apparently simple and straightforward way to control Medicare outlays is to limit annual increases in reimbursement rates. This option comes with the obvious risk that if Medicare reimbursement falls far short of rates obtainable from private payers, providers will increasingly refuse to serve Medicare patients or will reduce the quality of services rendered to them.

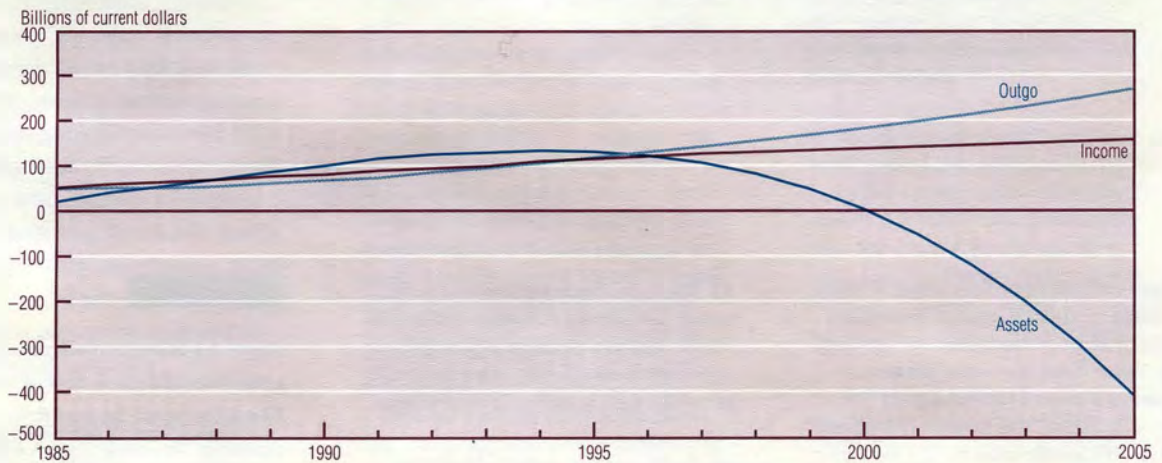
The two most important reimbursement reforms adopted since the early 1980s had only limited success using the cost-control approach. The first was the prospective payments system, which remunerates hospitals at a fixed rate per health care episode. Because hospitals do not receive extra payments for extra services rendered, they have an incentive to cut back on the amount of service they provide. The second major reform is the "relative-value" scale for reimbursing doctors, who were previously paid based on "usual and customary" charges.⁸

Both of these measures succeeded in slowing the growth rate of inpatient hospital and doctor services.⁹ However, because providers reacted by substituting services that are not subject to the prospective payments system (home health care and skilled nursing facilities), total Medicare outlays continued to spiral upward.¹⁰

The introduction of the prospective payments system in 1983 had little effect on the overall quality of care the elderly received, since close, unregulated substitutes for inpatient hospital stays were available.¹¹ Today, however, extending this system to a wider range of health care services, apart from inducing a general withdrawal of services from Medicare beneficiaries, could also lower their quality of care if more skilled and qualified providers begin to serve only privately insured patients.

Scaling back provider reimbursements is also likely to convince some beneficiaries to switch to managed care plans.¹² Generally, healthier individuals tend to enroll in HMOs. Because Medicare's payment to these organizations is based on the average cost per patient in the fee-for-service sector, where individuals are less healthy on average, HMO enrollment is more expensive than it would be if the relatively healthy beneficiaries remained in the fee-for-service system. Thus, unless payments to HMOs are adjusted to reflect enrollees' lower health risks, a large migration of Medicare recipients to these plans may raise rather than lower Medicare outlays. It is also unclear whether HMOs will be able to maintain broad coverage and high-quality service despite the infusion of marginally less healthy enrollees and lower risk-based payments. Finally, even if Medicare costs are reduced, this may turn out to be a one-time event that does nothing to limit the *growth* of Medicare outlays.

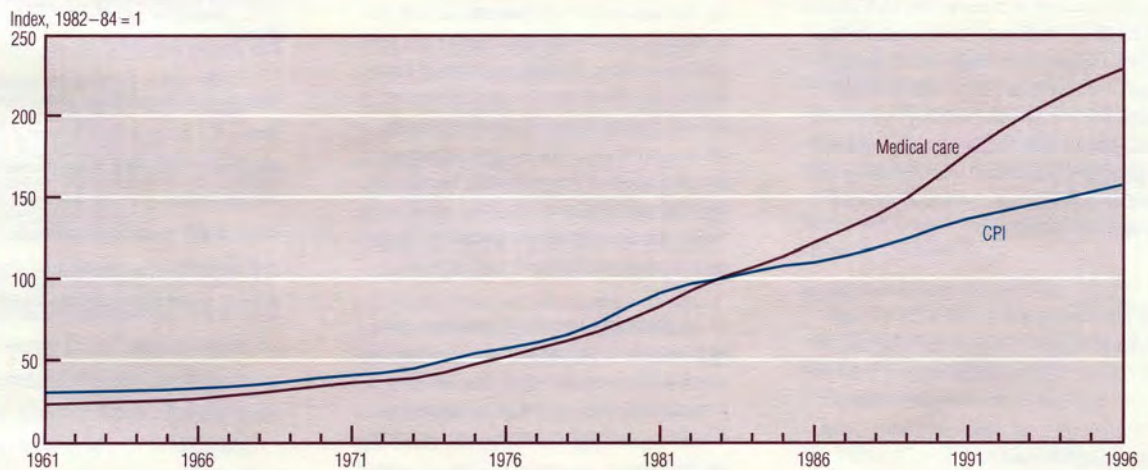
FIGURE 1: THE HOSPITAL INSURANCE TRUST FUND: RECENT HISTORY AND PROJECTIONS



NOTE: Calendar-year data.

SOURCE: 1996 Annual Report of the Board of Trustees of the Hospital Insurance Trust Fund (footnote 2).

FIGURE 2: THE MEDICAL CARE PRICE INDEX VERSUS THE CONSUMER PRICE INDEX



SOURCE: *Economic Report of the President*, 1997.

■ Eligibility Age and Out-of-Pocket Costs

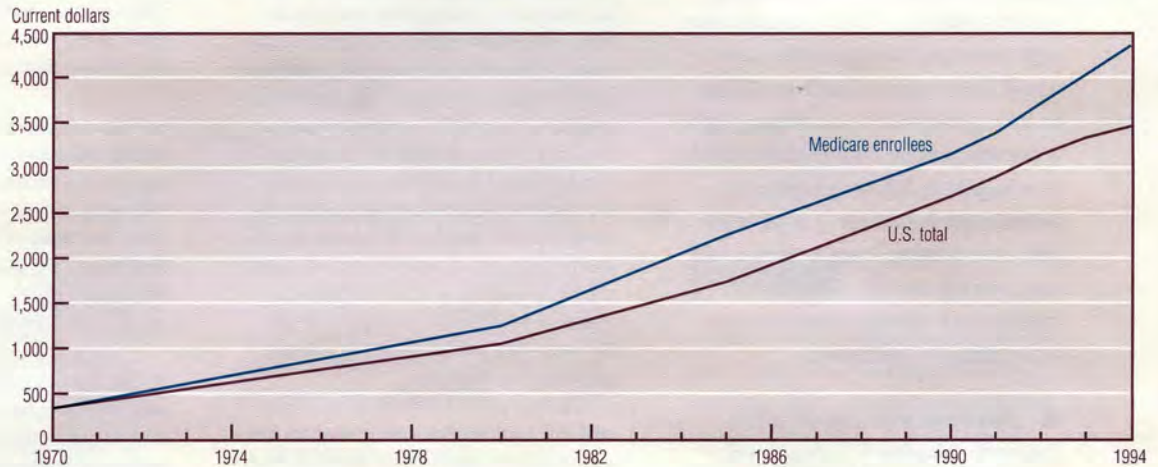
One of the long-term financing reforms suggested during the recent debates is gradually raising the age of Medicare eligibility from 65 to 67 or 70. This would increase out-of-pocket costs for many individuals who opt for early retirement, especially those residing in states with no post-retirement continuation-of-coverage laws for employer-provided health insurance. Contrary to Medicare's fundamental objective, it would also leave a growing segment of the older population with no health care coverage.

A second proposal for trimming overall costs consists of increasing Medicare deductibles and copayments.¹³ Higher and more comprehensive use of deductibles, if they "reached" beneficiaries, would boost retirees' incentives to economize on their use of health care services. However, most beneficiaries purchase Medigap policies that insulate them from the incentive effects of higher deductibles and copayments.

■ Medical Savings Accounts

Another proposal to help keep Medicare afloat is establishing medical savings accounts (MSAs) for beneficiaries. This strategy has three main features. First, Medicare would pay a fixed amount (indexed for inflation) into beneficiaries' MSAs. Second, a portion of this amount would be used to purchase a high-deductible health insurance policy. Third, the remaining money could be withdrawn to meet expenses below the deductible when needed on a pre-tax basis, or for other consumption on an after-tax basis. Proponents of this

FIGURE 3: PER CAPITA SPENDING ON MEDICAL SERVICES



SOURCE: Congressional Budget Office, *Trends in Health Spending: An Update*, June 1993.

approach claim that because beneficiaries would have to pay all expenses that fall below the deductible, and because they could use the funds for other consumption, they would have a stake in using medical services wisely.

Unfortunately, MSAs are likely to prove inadequate in curbing overall costs. Because of the high-deductible—and therefore low-cost—insurance policies allowed, only relatively healthy individuals would opt for MSAs. The average cost of those remaining in the fee-for-service system would thus increase, inducing more beneficiaries to join MSAs or managed-care plans. This process would continue until only the sickest individuals were left in the fee-for-service sector. Then, if Medicare contributions to MSAs were based on the average cost of fee-for-service patients, instead of being adjusted for the lower health risks of the MSA beneficiaries, total Medicare outlays might actually rise.¹⁴ Moreover, some MSA participants might opt to shift back to Medicare's fee-for-service system if they become ill but have already exhausted most of their medical account for nonmedical purposes.¹⁵ This could destabilize the pool of MSA participants, making it difficult to estimate the appropriate risk adjustment for Medicare's MSA contributions.

A further shortcoming of tax-favored MSAs is that they confer yet another subsidy on the consumption of medical services. Employer-provided health insurance already receives preferential tax treatment—a provision that many believe fosters a greater demand for health care services and causes costs to soar. Adding another subsidy for health care consumption would only reinforce this effect.¹⁶

■ A “Defined Contributions” Approach

Boosting consumers' interest in the selective use of medical resources requires that *they* be the ones making spending decisions at the margin. This means that the government must minimize its role in defining both the types of coverage and services available to Medicare beneficiaries and the level of premiums and deductibles that it charges for them. One way to accomplish this is through a “defined contribution” system incorporating two essential features: First, Medicare would provide a fixed contribution (or vouchers) to each beneficiary for the purchase of private health insurance.¹⁷ Second, beneficiaries would augment Medicare's contribution by using personal resources to buy more

expensive policies or, if preferred, cheaper ones, with the difference being rebated to them at year's end. This is different from the MSA alternative because it does not restrict consumers' choice of plan and because it is applicable to all beneficiaries, regardless of whether they are enrolled in HMOs.

Such a payment structure would force beneficiaries to pay the last dollar of coverage, which in turn would require them to evaluate the benefit from spending that dollar. Consumers, being the best judges of their own health risks and preferences, would be able to tailor coverage to their particular needs and avoid purchasing more generous coverage than is warranted. Consumers' efforts to pare back their medical spending are likely to heighten the competition among insurers and providers. Hence, policy premiums and service charges would be based on the outcome of a competitive bidding process that would link prices and premiums closely to costs.

One drawback to this approach is that sicker individuals may be exposed to greater health risks, since premiums for high-coverage, low-deductible plans would likely surge as healthier persons increasingly opt for low-coverage, high-deductible policies. This problem could be mitigated by adjusting Medicare's defined contribution for specific health risks. For example, contributions could vary with age and sex so that more resources are directed to those retirees most in need of health care.

■ Diagnosis and Prescription

Rather than dealing with Medicare's structural shortcomings, the recent budget agreement would reduce provider reimbursements and extend the prospective payments system to a wider array of health care services. These measures would push the projected date of insolvency ahead by a few years, but would do little to improve the efficiency and incentives of our current health care delivery system. In fact, they may lower the quality of care that elderly Americans receive.

Medicare's financing problem is a consequence of the third-party payment system that prevails in the United States. Hence, structural reforms that maximize consumers' and providers' incentives to economize on their use of health care resources are crucial. Among the various options, shifting to a defined contribution system appears to be the most promising. The contribution of a fixed amount by Medicare (adjusted for inflation, age, and sex) toward the purchase of private health insurance—accompanied by the freedom to augment coverage out of private resources or to reduce coverage and pocket the difference—would enhance consumers' incentives to stretch their health care dollars. Furthermore, consumer cost consciousness is likely to boost competition among health care professionals and insurers. With the baby boomers on the cusp of retirement, adopting such a plan should be one of the nation's top priorities.

■ Footnotes

1. Medicare provides benefits in kind; that is, it reimburses medical care providers directly rather than sending payments to beneficiaries. Most Medicare recipients purchase private Medigap insurance, which covers any premiums, deductibles, or copayments that Medicare imposes or does not reimburse. The facilities that provide medical services are mainly fee-for-service organizations that are reimbursed based on the number of services they provide. A small fraction of beneficiaries are enrolled in health maintenance organizations (HMOs), which provide all necessary care in return for a fixed annual payment from Medicare.

The other public health program, Medicaid, is a means-tested welfare program that extends health benefits to the poor. Many of its beneficiaries also qualify for Medicare. Medicaid is administered by the states and is financed partly from federal grants out of general revenues. This article, however, focuses exclusively on the financing problems of Medicare.

2. See the *Annual Report of the Board of Trustees of the Hospital Insurance Trust Fund*, Washington, D.C.: U.S. Government Printing Office, 1996. Medicare Part A, which covers inpatient hospital services, home health care, hospice care, and skilled nursing care, is financed through the Hospital Insurance (HI) trust fund, which is projected to become insolvent. Its income (2.9 percentage points of the payroll tax and a portion of the revenue generated by the tax on Social Security benefits) will fall short of projected outgo by the year 2001. Medicare Part B covers outpatient services and physicians' fees and is financed out of general government revenues and premiums charged to beneficiaries via the Supplementary Medical Insurance trust fund (SMI). Because SMI is paid for out of the general government account, its solvency is not in question.

3. The U.S. budget for fiscal year 1998 called for a \$100 billion reduction in Medicare outlays. (Editor's note: This article went to press on July 14, 1997.)

4. It is not my purpose to debate the rationale behind government-subsidized health care for retirees. Rather, I discuss the merits of alternative ideas for reforming the existing program in light of its impending insolvency. The "structural" reforms I discuss here can be defined as changes that will restore consumers' incentive to economize on their health care spending while also preserving the quality of health care services.

5. Because consumers do not bear the marginal cost of additional health care services, they would use these services until the marginal benefit was zero, regardless of the cost of providing them.

6. One recent study shows that malpractice liability reform may reduce medical spending by 5 to 9 percent without significantly increasing mortality or medical complications. See Daniel P. Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, vol. 111, no. 2 (May 1996), pp. 353–90.

7. The increase in per capita spending could have resulted from higher outlays by all enrollees or from an uptick in the relative number of older enrollees, who spend more, on average, than younger ones. Because the age composition of the Medicare population has not changed much during the last three decades, the first reason accounts for most of this trend.

8. The resource-based, relative-value scale is a national uniform gauge of relative values for all physician services. It includes the relative value of a procedure, practice expenditures net of malpractice expenses, and the cost of professional liability insurance. The scale is modified by a geographic adjustment factor, and base amounts are regularly updated for inflation.

9. In part, cost controls have reduced Medicare outlays because providers have subsidized Medicare patients by shifting costs to their non-Medicare clients.

10. Medicare outlays for hospital reimbursements are projected to grow 5.3 percent per year through 2002, but the figures for home health care and skilled nursing services are more than twice as large—11.9 and 11.2 percent, respectively. See *The Economic and Budget Outlook: Fiscal Years 1998–2007*, Congressional Budget Office, January 1997.

11. Evidence shows that the quality of care worsened for inpatient hospital care after the prospective payments system (PPS) was implemented. The post-PPS reduction in average reimbursement rates for inpatient care seems to have increased the probability of dying in the hospital, but it lowered the probability of being readmitted, possibly because of a composition effect; that is, fewer of those who would have been readmitted survived the initial hospital visit. In general, patients now die closer to the date of admission. The post-PPS imposition of marginal costs on hospitals appears to have reduced inpatient mortality, but it has increased the probability of readmission. According to one

recent study, the most likely reason for this is a change in hospitals' accounting methods: Sicker patients are readmitted for "upcoding" into higher diagnostic-related groups to increase total hospital reimbursements. See David M. Cutler, "The Incidence of Adverse Medical Outcomes under Prospective Payment," *Econometrica*, vol. 63, no. 1 (January 1995), pp. 29–50.

12. Only 10 percent of Medicare beneficiaries are currently enrolled in managed-care plans. Even with no policy changes, however, this fraction is expected to reach 25 percent by 2002. There are two reasons for this projected trend. First, a substantial percentage of new enrollees (those who have just reached their sixty-fifth birthday) are already enrolled in HMOs. Second, escalating Medi-gap premiums associated with the rising cost of fee-for-service plans are likely to make HMOs more attractive.

13. In 1996, Medicare charged deductibles of \$100 for doctor services and \$736 for inpatient hospital care. Hospital stays beyond 60 days entailed out-of-pocket costs of \$184 per day. No deductibles are charged for home health care services, whose utilization rates are growing the fastest.

14. It is instructive to note that despite the similar self-selection of healthier patients into HMOs, Medicare payments to managed-care organizations are currently based on average per patient costs in the fee-for-service sector.

15. Restricting the use of MSAs for non-medical consumption would prevent this type of moral hazard problem. However, if the funds cannot be used in an alternative manner, it would also reduce beneficiaries' incentive to economize on medical spending.

16. Because infectious diseases can turn into epidemics, maintaining good health has positive externalities. Medical care should therefore be subsidized, but the optimal amount is difficult to determine. The argument in the text is motivated by the fact that employer-provided medical care is already heavily tax-favored, and additional subsidies would only worsen the fiscal problems caused by the burgeoning demand for health care services.

17. A minimum amount of coverage could be mandated to protect individuals from catastrophic illnesses. However, beyond this requirement, there would be no constraints stipulating deductible, copayment, or coverage levels.



Jagadeesh Gokhale is an economic advisor at the Federal Reserve Bank of Cleveland. The author thanks Michael Bryan, Charles Carlstrom, Ben Craig, Joseph Haubrich, and E.J. Stevens for helpful comments on earlier drafts.

The views stated herein are those of the author and not necessarily those of the Federal Reserve Bank of Cleveland or of the Board of Governors of the Federal Reserve System.

Economic Commentary is available electronically through the Cleveland Fed's site on the World Wide Web: <http://www.clev.frb.org>. We also offer a free on-line subscription service to notify readers of additions to our Web site. To subscribe, please send an email message to econpubs-on@clev.frb.org.

**Federal Reserve Bank of Cleveland
Research Department
P.O. Box 6387
Cleveland, OH 44101**

Address Correction Requested:
Please send corrected mailing label to the above address.

Material may be reprinted provided that the source is credited. Please send copies of reprinted materials to the editor.

**BULK RATE
U.S. Postage Paid
Cleveland, OH
Permit No. 385**