# CATO HANDBOOK FOR CONGRESS

**Policy Recommendations for the 108th Congress**

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# 26. Public Health Care

***Congress should***

- fundamentally restructure Medicare to expand competitive private health plan choices;
- not add comprehensive prescription drug benefits to Medicare unless and until it enacts structural reform of the entire program;
- encourage states to adjust Medicaid eligibility criteria and covered benefits to serve fewer nondisabled, lower-income individuals—but then provide remaining beneficiaries with higher-quality core health services and make greater use of cost-sharing incentives; and
- facilitate state efforts to adapt defined-contribution-style financing as an option for Medicaid beneficiaries.

Over the past two years, Congress has again backed away from taking on necessary restructuring of Medicare while private health options under the Medicare + Choice program have continued to shrink rather than expand. Meanwhile, efforts to add a new runaway entitlement program for prescription drug benefits came up short in the Senate after the House narrowly approved its own flawed measure that strained to preserve the appearance, but not the reality, of competitive and privately managed Medicare drug insurance.

Congress also entertained proposals to expand eligibility for Medicaid coverage to uninsured lower-income workers, to increase the federal matching payments to state Medicaid programs, and to begin a federal takeover of certain subsidy payments to ''dual eligible'' Medicare/Medicaid beneficiaries; none of those measures became law.

In short, the status quo prevailed. Congress refrained from doing more harm in both programs, but it also failed to make any progress toward moving current and future beneficiaries away from unsustainable depen-

dence on two aging Great Society entitlement programs born in 1965 that suffer from their own sets of worsening chronic conditions and disabilities.

## Medicare's Midlife Crisis

Despite a few recent years of improved financial performance, Medicare remains fundamentally flawed after 37 years in operation, and it is unsustainable on a long-term basis. The Balanced Budget Act of 1997 launched a new round of arbitrary price controls, regulatory complexity, and overzealous ''fraud and abuse'' enforcement that temporarily slowed the rate of growth of Medicare spending. But Medicare's Hospital Insurance (Part A) trust fund will resume spending more than it collects in taxes in 2016, and it faces a long-term actuarial deficit of 2 percent of taxable payroll. The Supplementary Medical Insurance (Part B) side of Medicare will continue to grow faster than both Part A and the overall economy. It will double its share of gross domestic product within 30 years.

The *2001 Financial Report of the United States Government,* prepared by the Financial Management Service of the Department of the Treasury, provides a more comprehensive view of the mounting burden that Medicare will impose on current and future taxpayers. Medicare spending exceeded the program's tax receipts and premiums by $59 billion in fiscal 2000, and the annual gap will grow to an estimated $216 billion (using constant dollars) in 2020. In 2002, Medicare program actuaries at the Centers for Medicare and Medicaid Services conservatively projected that the discounted net excess of cash spending over cash income during the next 75-year period would be $5.1 trillion (even after including Medicare trust funds' balances and future interest income, as well as general revenue transfers to Part B). However, the *Financial Report* calculations from one year earlier, using accrual accounting under generally accepted accounting principles and therefore excluding interest payments and other intragovernmental transfers, estimated that the net present value of negative cash flow (funds needed to cover projected shortfalls) was $4.7 trillion for Part A and an additional $8.1 trillion for Part B (Table 26.1).

Working Americans remain on the hook for a rising share of the imminent cost explosion. Federal general revenues already finance 25 percent of Medicare spending; that share will rise to more than half within 30 years. More than 37 years after it began in 1965, Medicare remains one of the most volatile and uncontrollable programs in the federal budget. Its unrestrained appetite will squeeze out other national priorities and jeopardize opportunities for future generations.

## *Table 26.1*
## *U.S. Government Statement of Social Insurance*
## *Present Value of Long-Range Actuarial Projections*[1]

| | Contributions and Earmarked Taxes[2] | | Benefit Payments[3] | | Benefit Payments in Excess of Contributions and Earmarked Taxes | |
|---|---|---|---|---|---|---|
| | 2001 | 2000 | 2001 | 2000 | 2001 | 2000 |
| **Participants Who Are Currently Receiving Benefits:** | | | | | | |
| Federal Hospital Insurance (Medicare Part A) | 113 | 97 | 1,693 | 1,681 | 1,580 | 1,584 |
| Federal Supplementary Medical Insurance (Medicare Part B) | 258 | 234 | 1,159 | 1,051 | 901 | 817 |
| **Participants Who Are Not Currently Receiving Benefits:** | | | | | | |
| Federal Hospital Insurance (Medicare Part A) | 4,136 | 3,757 | 8,568 | 6,702 | 4,432 | 2,945 |
| Federal Supplementary Medical Insurance (Medicare Part B) | 1,845 | 1,527 | 7,415 | 6,094 | 5,570 | 4,567 |
| **Future Participants:**[4] | | | | | | |
| Federal Hospital Insurance (Medicare Part A) | 3,507 | 3,179 | 2,225 | 1,349 | (1,282) | (1,830) |
| Federal Supplementary Medical Insurance (Medicare Part B) | 593 | 404 | 2,206 | 1,514 | 1,613 | 1,110 |

*(continued)*

## *Table 26.1 (continued)*

| | Valuation Period | Valuation Date | Net Present Value of Negative Cash Flow[5] |
|---|---|---|---|
| Federal Hospital Insurance (Medicare Part A) 2000 | 1/1/2000–12/31/2074 | 1/1/2000 | 2,699 |
| Federal Hospital Insurance (Medicare Part A) 2001 | 1/1/2001–12/31/2075 | 1/1/2001 | 4,730 |
| Federal Supplementary Medical Insurance (Medicare Part B) 2000 | 1/1/2000–12/31/2074 | 1/1/2000 | 6,494 |
| Federal Supplementary Medical Insurance (Medicare Part B) 2001 | 1/1/2001–12/31/2075 | 1/1/2001 | 8,084 |

SOURCE: *Financial Report*, United States Government Stewardship Information for the Years Ended September 30, 2001, and September 30, 2000 (unaudited).

Note: figures are billions of dollars.

[1]Present values are computed based on the economic and demographic assumptions believed most likely to occur (the intermediate assumptions) as set forth in the related Trustees' reports.

[2]Contributions and earmarked taxes consist of payroll taxes from employers, employees, and self-employed persons; revenue from Federal income taxation of OASDI; and monthly Medicare Part B premiums paid by, or on behalf of, beneficiaries. Contributions and earmarked taxes for the Medicare Part B program presented in this report are presented on a consolidated perspective. Interest payments and other intergovernmental transfers have been eliminated. The Centers for Medicare & Medicaid Services' (CMS), formerly known as the Health Care Financing Administration (HCFA), 2001 Annual Report presents income from the trust fund's perspective, not a Government-wide perspective. Therefore, CMS's Annual Report includes $8,084 billion for the present value of transfers from the general fund of the Treasury to the Medicare Part B Trust Fund that have been eliminated in this *Financial Report*.

[3]Benefit payments include administrative expenses.

[4]Includes births during the period and individuals below age 15 as of January 1 of the valuation year.

[5]The net present value of negative cash flow is the current amount of funds needed to cover projected shortfalls, excluding trust fund balances, over the 75-year period. The trust fund balances at the beginning of the valuation period that were eliminated for this consolidation were: $177 billion—Medicare Part A and $44 billion—Medicare Part B. The projection period for new entrants covers the next 75 years for the Medicare program. The projection period for current participants (or ''closed group'') would theoretically cover all of their working and retirement years, but as a practical matter, the present values of future payments and contributions for/from current participants beyond 75 years are not material. The actuarial present value of the excess of future benefit payments to current participants (that is, to the closed group of participants) over future contributions and tax income from them or paid on their behalf is calculated by subtracting the actuarial present value of future contributions and tax income by and on behalf of current participants from the actuarial present value of the future benefit payments to them or on their behalf.

Moreover, simply struggling to preserve the current Medicare program, without substantial improvements and structural change, would ignore the needs of current and future beneficiaries. Medicare's basic benefit package has become increasingly outdated and inflexible. Traditional coverage fails to protect seniors against catastrophic medical bills or against almost any outpatient prescription drug expenses at all. Resolution of many coverage and reimbursement issues is hampered by inefficient, interminable, and inconsistent administrative determinations. For example, Medicare administrators took an average of 383 days to make and implement a national coverage decision in FY01. But, according to the Advanced Medical Technology Association, it then may take the Centers for Medicare and Medicaid Services an additional two years or more to assign codes and set payment rates for a new technology or service.

Physicians face mounting burdens of Medicare paperwork and incomprehensible regulatory edicts that reduce the time they can spend with their patients. Doctors also fear unwarranted accusations of fraud and harsh sanctions by Medicare enforcement officials, according to the Medicare Payment Advisory Commission. On top of that, Medicare reimbursement formulas cut payments to doctors by more than 5 percent in 2002. Current law requires overall reductions of 17 percent in Medicare fees paid for each medical service from 2002 to 2005. Not surprisingly, growing numbers of physicians are refusing to take new Medicare patients.

Although the 1999 bipartisan commission on Medicare sketched out some promising structural reforms, further actions to follow up on them and overhaul Medicare have languished, at best, in Congress. Instead, Congress has preferred to debate to a standstill an expanded Medicare entitlement to prescription drug coverage.

The next round of Medicare reform should emphasize structural change over short-term budget savings targets. The bungled experiment in Medicare + Choice must be repaired. Although the M + C program aimed at offering consumers more choice, a smaller percentage (14 percent) of Medicare beneficiaries was enrolled in private plans during 2001 than before the program was launched in 1997. The program has been plagued by withdrawals of and service reductions by private health plans. Very few insurers offered non-health-maintenance-organization (HMO) options, such as preferred provider organizations (PPOs) or private fee-for-service plans, and no carrier has ever offered a medical savings account (MSA) plan.

New payment methods established by the Balanced Budget Act largely failed to achieve their goal of limiting geographic variation in M + C

payment rates, but they had the unintended consequence of paying too little in the most promising markets for expansion of private plan options. Early bureaucratic efforts at full risk adjustment in payments to plans were ineffective and suspended.

Congress needs to begin again with a blank sheet of paper and proceed to eliminate the uncertainties and excesses of its complex regulatory requirements, time limits, and payment methodologies for the faltering M + C program. Creation of a sustainable framework for Medicare modernization requires moving from an antiquated defined-benefit structure (which covers a specific set of health services) to a defined-contribution model, under which seniors could choose among competing packages of health benefits with taxpayers' costs capped at preset levels.

It is crucial that the traditional Medicare fee-for-service coverage program be required to improve by competing for market share on a level playing field. Many Medicare reformers emphasize the enhanced benefits and higher-quality care that new private plan options might make available to beneficiaries, but they tend to underplay, if not neglect, the key ingredients needed to make those improvements affordable. One necessary element includes a payment system under which private plans bid to provide required benefits, beneficiaries capture the savings from choosing less-costly options, and the government's share of Medicare funding reflects the enrollment-weighted average costs of the mandatory benefits provided in all plans (including traditional Medicare).

Seniors seeking additional supplemental benefits would pay higher premiums for them that would reflect their marginal costs. Because the same insurer would provide both the required benefits and the supplemental benefits, separate Medigap insurers that currently remove cost-sharing incentives within basic coverage would no longer be able to pass on to taxpayers the higher costs of additional spending. Medicare beneficiaries who accepted greater individual responsibility would be rewarded with broader health coverage choices and possible cash rebates.

Defined-contribution payments must be determined by competitive market prices, instead of remaining linked to the politically driven and bureaucratically administered price controls of the traditional Medicare program. Competitive bidding mechanisms and reasonable ground rules for periodic open enrollment choices offer great promise for ending distorted prices and poor information.

Other fundamental Medicare reforms include scrapping the mirage of trust fund financing, particularly the arbitrary shell game distinctions

between the Part A trust fund (financed by payroll taxes) and the Part B trust fund (financed approximately three-quarters by general revenues and one-quarter by beneficiary premium payments).

Adding prescription drug benefits to Medicare should accompany, not precede, such structural reform. An updated M + C program and a restructured version of traditional Medicare could offer a range of enhanced drug options to beneficiaries willing to pay for them, perhaps through greater cost sharing for other covered benefits. Encouraging insurers to assemble packages of linked benefits would provide the greatest value by coordinating tradeoffs between drugs, surgery, hospitalization, and outpatient care as treatment options.

Congress must continue to resist the impulse to spread a wide and thin layer of visible, first-dollar drug subsidies to all Medicare beneficiaries, regardless of need, rather than target them more narrowly to support more generously those seniors most in need of assistance. Simply adding a new round of underfunded, irresponsible promises to Medicare will stimulate beneficiary demand for ''cheap'' drugs and overuse of those benefits. It is sure to be followed by exploding budgetary costs and increases in the ''unsubsidized'' price of Medicare's prescription drugs. Next will come waves of drug coverage rollbacks, regulatory restrictions, tighter drug formularies, and price controls that chill future innovative research and snuff out the next round of life-saving drugs.

It's the same old dead-end path to the Medicare Money Pit that we've already traveled down for hospital and physician services. The full costs of government-mandated ''price discounts'' eventually include reduced access to quality care and destabilized health care markets.

If Congress cannot resist the urge to add drug benefits without tackling fundamental Medicare reform, it should at least do less harm by emphasizing higher deductibles and catastrophic loss protection for prescription drug coverage, targeted assistance to lower-income seniors, and reformed coverage for individual Medigap purchasers. Under no circumstances should the door be opened to universal subsidies to seniors for routine, manageable drug expenses.

The average out-of-pocket drug expenditure for all Medicare enrollees in 2001 was about $650. Let's place the prescription drug issue in perspective by first dealing effectively with the small slice of Medicare beneficiaries (fewer than 10 percent) that faces more than $2,000 a year in out-of-pocket drug expenses, as well as with lower-income beneficiaries just beyond the eligibility limits for Medicaid drug assistance.

An initial round of the intermediate reform measures suggested above would help realign the current Medicare structure to allow its later transformation into a fully privatized system of health care choices for seniors. Congress should give careful consideration to eventually making it possible for younger workers to divert some or all of their Medicare payroll taxes into savings vehicles that would prefund their purchase of private health insurance when they reach retirement age. Transitional finance issues may slow the evolution toward this ultimate objective, but a full return to individual responsibility and private-sector health care offers the only long-term hope for surmounting the chronic financial crises and bureaucratic morasses of Medicare as we know it.

## *Up and Away from Medicaid Dependence*

Over the past 15 years, Medicaid program outlays grew more than any other area of federal entitlement spending. Medicaid trails Social Security and Medicare as the third largest entitlement program. When Medicaid spending grew by 11 percent in FY01, it marked the fifth consecutive year that the program's spending growth accelerated. The Congressional Budget Office estimates that the federal share of Medicaid spending will grow at an average rate of 8.5 percent over the next 10 years.

Medicaid is a complex, patched-together assortment of four different types of public insurance programs for various categories of low-income Americans. It provides medical insurance for low-income women and their children. It pays medical bills for the low-income disabled. It finances a large portion of nursing home expenses for the elderly. It also picks up some of the other health costs of the ''dual eligible'' elderly that are not covered by Medicare (such as deductibles, coinsurance, Part B premiums, and outpatient prescription drugs).

The program is not just terribly costly, it is prone to mismanagement as an unwieldy mix of shared federal and state administrative responsibilities. More fundamentally, Medicaid is handicapped by its flawed welfare entitlement structure that still largely remains linked to one-size-fits-none sets of defined benefits. Medicaid continues to be plagued by poor quality health care and inadequate reimbursement levels. It keeps trying to promise more yet delivers less and less.

Federal policy encouraged states to expand eligibility for and services covered by their Medicaid plans over the last decade. State governments were eager to do so, because federal taxpayers picked up roughly 50 percent to 83 percent of Medicaid costs under matching formulas, depending

on the particular state involved. States even exploited program funding loopholes to funnel more federal dollars into their coffers through such devices as phony ''tax payments and donations'' from providers and artificially higher state payments to public medical facilities that qualified for disproportionate share assistance.

The states belatedly discovered that they had indulged in too much of a good thing in leveraging their share of Medicaid financing. Over the last two years in particular, state Medicaid spending exploded at the same time that state revenue growth first slowed and then declined. Although state Medicaid program directors are beginning to learn that they cannot make up their losses on more volume, they have remained reluctant to cut back on their irrationally exuberant eligibility expansions of the 1990s. Instead, they generally have preferred to keep provider reimbursement rates well below market levels, blame pharmaceutical manufacturers for rising drug costs, and beg for larger federal matching payments.

Congress should resist pressure to expand the Medicaid program to new classes of beneficiaries, and it should encourage the states to put their own fiscal houses in order. The Bush administration's aggressive use of Medicaid waivers has provided more flexibility for state Medicaid programs. Its Health Insurance Flexibility and Accountability initiative allows states to reduce benefits and increase cost sharing, but with an unfortunately one-sided bias toward expanding the number of beneficiaries covered. The political danger of buying greater ''market share'' for Medicaid at loss-leader prices is that initial limits on benefits and coverage levels might not be politically sustainable.

State Medicaid programs need to rethink their policy priorities in balancing Medicaid spending with other claims on overstretched budget dollars. They should adjust eligibility criteria and covered benefits to serve fewer nondisabled and (relatively) higher-income individuals—but then provide those beneficiaries with higher quality health services. Instead of finding new ways to pay medical providers even less money per billable charge, they should focus on paying primary care doctors more adequately, making greater use of copayments and cost-sharing incentives, and reducing other optional Medicaid services. It's also more important to maximize coverage of the lowest-income individuals and families that are eligible for Medicaid but have few other insurance alternatives than to expand coverage to relatively higher-income groups.

Benefit payments for low-income adults and children are not major cost drivers. Those people represent about three-fourths of eligible benefici-

aries, but they account for only about one-fourth of total program costs. Disabled individuals below age 65 constitute the fastest growing group eligible for Medicaid and account for the fastest growing slice of Medicaid spending. Medicaid spending per capita is highest for the low-income elderly, primarily in the form of payments for long-term care in nursing homes.

Although the cost of Medicaid drug benefits has been growing at eye-popping rates in recent years, it totaled just 11 percent of Medicaid spending in 2000. Medicaid beneficiaries who are either elderly or disabled accounted for almost 80 percent of those drug expenditures. Yet the health of the elderly has been improving since the early 1980s, particularly in terms of reduced rates of disability, because of improvements in medical technology and health knowledge. Given that development of innovative drug treatments has played a large role in this progress, recent state efforts to leverage further price rebates out of drug makers through tighter formularies and ''reference price'' ceilings may end up being penny-wise and pound-foolish in terms of overall Medicaid costs if they cut off access to new breakthrough drugs. Greater use of multitiered cost sharing provides a more flexible mechanism for slowing skyrocketing rates of prescription drug cost growth without arbitrarily restricting access to therapeutically necessary medicines.

Ironically, disability rates among younger Americans (and eligibility for Medicaid benefits) have been growing. This problem is best addressed by reexamining loosened requirements for disability eligibility; improving incentives for many disabled beneficiaries to build capital, reenter the workforce, and regain self-sufficiency; and expanding promising ''Cash and Counseling'' demonstration projects already under way in several states.

The benefits of more generous state Medicaid policies for nursing home reimbursement have largely accrued to children who would otherwise have to support and live with their elderly parents. Eligibility for Medicaid assistance in paying nursing home costs should be targeted more narrowly to the genuinely needy in order to provide stronger financial incentives for aging baby boomers and future generations to purchase private long-term care insurance.

Despite early enthusiasm on the part of many state governments for contracting with private HMOs to coordinate medical care for Medicaid recipients, a recent empirical review by Mark Duggan of the University of Chicago demonstrated that switching from fee-for-service to Medicaid managed care was associated with a substantial increase in government spending but no observable improvement in health outcomes.

A more ambitious intermediate-range Medicaid reform agenda should include more efforts to adapt defined-contribution-style financing as an option for beneficiaries so that they could control more of the content of their benefits packages and capture the gains from spending less on covered health services. Health care value is maximized better by ''fixing'' the total cost of benefits under an insurance model that then allows eligibility, the scope of benefits, and service quality to vary. Traditional Medicaid program rules instead concentrate on fixing the scope of benefits and eligibility criteria under an entitlement model that then focuses on budget costs as the key variable (and treats quality and access as less important considerations). Federal waiver authority should allow individual Medicaid beneficiaries to claim their ''share'' of annualized capitated payments within state managed care programs as a private health insurance voucher. Those beneficiaries who chose to opt out of such programs could then purchase other forms of private insurance coverage, as defined in the Health Insurance Portability and Accountability Act. States would be allowed to waive certain mandatory Medicaid benefits requirements to allow greater cost-sharing and economizing incentives.

Long-term reform will require that states be weaned from the federal matching rate formula that encourages them to chase their fiscal tails in search of federal dollars even as their state budgets plummet deeper into fiscal holes.

### *Suggested Readings*

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