

## **Health Issues in Living Longer and Living Better**

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Health care for older Americans plays a critical role in determining whether Americans are living longer and living better; and in turn, longer lives pose challenges for the public programs that serve this population. Medicare and Medicaid represent success stories in improving access to health care for seniors. Without these programs, some of the progress in life expectancy and lower morbidity would not have occurred. And because health care costs are likely to continue to grow as a share of our economy, affording care in the future will also mean an important role for public policy.

The aging of the baby boom generation will clearly have a major impact on the numbers of persons over the age of 65 in the United States. But also important is increasing life expectancy. As a result, the population profile for the future is not the infamous "pig in a python" that people used to discuss, but rather a "python in a python." We are facing not just a period of time in which older persons will increase as a share of the population, but a permanent shift to a society with a large number of senior citizens. This will place increased demands on all public sources of expenditure for older Americans.

Rather than looking forward to ways to improve Medicare and Medicaid for the future, however, much of the rhetoric since the 1980s has been of Medicare as an "unsustainable" program that must be dramatically overhauled as we move into the 21st century. Spending on the program of \$213 billion in 1999 certainly represents a large commitment of resources and one that is projected to rise substantially over time. But calls for major reform to "save" Medicare could lead to changes that would undermine the program's basic strengths. Implicitly, such efforts could place a greater burden on Medicaid to fill in the gaps, or effectively replace it if Medicare were also to become an income-related program. This brief paper focuses mainly on Medicare since it is likely to be in the front lines initially. Medicaid, on the other hand, has not nearly been as much in the public eye, although it too will likely face greater demands as the population ages.

### **The Accomplishments of Medicare and Medicaid**

Before examining the issues facing these program in the future, it is appropriate to review the improvements in the lives of older Americans that these two health insurance programs have achieved. As the larger and primary source of insurance for this population, Medicare receives more attention, but Medicaid plays an important role both in covering the gaps that Medicare leaves for those with low incomes and offering the primary source of long term care support for older Americans.

When Medicare began in 1966, it almost immediately doubled the share of persons aged 65 and over covered by insurance. Before Medicare, only about half of persons in this age group had insurance (Andersen, Lion, and Anderson, 1976). By 1970, 97 percent of older Americans were enrolled, and that proportion has remained about the same ever since (Moon 1996).

Two effects followed immediately: use of services by the population grew and financial burdens on older Americans and their families declined. Thus, access increased, particularly for those who previously lacked the resources to obtain services. Although Medicare's benefit package has changed little since 1965, in those areas where services are covered, the program has kept up with the times. Many surgeries are now performed on an outpatient basis, for example. Today, even the oldest old have access to mainstream medical care. New technology is available to beneficiaries and in some cases, the dissemination of new procedures occurs at a faster pace for the old than for the young (Moon 1999).

Perhaps even more important, Medicare played a crucial role in speeding the desegregation of hospitals

and other medical facilities, ensuring not only that minority seniors would receive care but that minorities of all ages would have access to health care services. It is easy to forget that in 1965, for example, many black Americans could not go to the best hospitals, particularly in the south (Height 1996; Stevens 1996).

Financial burdens for seniors also fell nearly in half as a result of Medicare and Medicaid. Over time, the share of income that seniors spend on health care has crept back up, but the burdens would be much greater if these programs were not there. In 1965, the typical elderly person spent about 19 percent of her income on health care. That share fell to about 11 percent in 1968. Today it is back up to 19 percent (see Figure 1). Medicare's contribution to the costs of health care for seniors totals over \$5300, nearly 40 percent of the median income of persons aged 65 and older. So, without Medicare, most of those now covered would pay more for their care, and many people would likely have to cut back on the amount of care they receive. Medicaid has also played an important role in filling in the gaps in spending for low income persons. It not only pays for the cost sharing and premiums that Medicare requires, but adds other services as well including prescription drugs and long term care. Participation remains a problem, however, with many low income persons who do not enroll facing very high out-of-pocket costs. The welfare nature of the program remains an important barrier to participation -- a fact that should not be lost in discussions about additional reforms to both programs.

In the area of the costs of care, Medicare can also point to substantial accomplishments. It was a leader in cost containment activities in the 1980s, improving upon payment to hospitals and doctors by shifting from a cost-based system to one in which payments are known and, in the case of hospitals, do not encourage excess use of services. Both of these systems have since been adopted by a number of other insurers. Further, these and other changes helped moderate the growth of Medicare spending such that, on a per capita basis, Medicare payments have grown more slowly than private insurance costs in most years (Levit et al 1999). Moreover, on a cumulative basis, Medicare has performed better than private insurance from 1970 to 1997 despite increased efforts in the 1990s by private insurance to limit costs by moving to managed care (Moon 1999).

Medicare has also changed over time to allow beneficiaries to choose to be served by private plans instead of remaining in the traditional fee-for-service part of the program. In 1997, this option was modified to allow plans other than health maintenance organizations (HMOs) to participate and to reform the payment system which, on average, costs Medicare more for each enrollee than if they remained in the traditional program (Riley et al 1997). This new Medicare + Choice benefit has been one of the least successful changes in Medicare. The limits imposed on payments have been strongly criticized by the private sector, creating an impasse in the program that will be difficult to overcome. Plans will likely continue to withdraw from participation and there will be efforts to increase payments to plans even if this means a less efficient Medicare program. Coordination with Medicaid programs that seek to enroll individuals in managed care is also an outstanding issue that needs attention.

Finally, improvements in life expectancy since 1965 have occurred at a faster pace for persons aged 65 and over than for the population as a whole. In 1960, women faced a life expectancy at age 65 of 15.8 years; by 1998, that figure was up to 19.2 years. For men, the increase in life expectancy over the same period was from 12.8 to 16 years (NCHS 2000). Some of this improvement is undoubtedly a by-product of Medicare and Medicaid. Improvements in disability also seem to be occurring, suggesting that these longer lives may often be healthier lives. But before we celebrate that such improvements will reduce future costs, it is important to note that the aging of the population will likely overshadow some of the disability improvements. Seniors in the 21st century will still need long term care as well as acute care services.

## **Projections of Medicare's Future Costs**

One way to look at the future costs of Medicare is to focus on the share of the gross domestic product (GDP) that the program would reach if no changes in policy were to take place (the so-called baseline numbers). Spending as a share of GDP is a useful measure because the projected dollars of spending get to be so large over time that they are hard to put in context. Moreover, this measure is relevant for assessing the combined costs of Parts A and B of the program (rather than just focusing on the status of the Part A trust fund).

Projections from the 2000 Trustees Report indicate that Medicare's share of the Gross Domestic Product (GDP) from both parts of the program will reach 3.95 percent in 2025, up from 2.29 percent in 1999 (Board of Trustees 2000). While the outlook has improved in the last few years, a substantial increase in the share of GDP devoted to care will occur over the next 25 years -- a 72.5 percent rise -- but the number of persons projected to be served will increase over the same period by 78.5 percent. At that time, Medicare will serve about one in every five Americans, up from one in eight today. Thus, a legitimate concern is to what extent it is desirable to drive spending lower, and if so, by how much?

Improved efficiency in the delivery of care ought to be a major goal, but it cannot and will not be the only solution to Medicare's financing problem given the challenges of a large older population. Further, a growing economy can absorb at least some higher spending on Medicare even if the same share of GDP is devoted to the program. That's because GDP is assumed to grow about 2.1 percent a year in real terms over time. But this is not fast enough to absorb both growth in the number of beneficiaries and per capita costs of care that rise faster than the general Consumer Price Index (CPI).

Over the years, the payroll tax contribution for Part A has been increased periodically. Even so, Part A financing has tended to lag behind growth in the costs of the program. For example, as early as 1970, the Part A trust fund was projected to be insolvent within just 2 years (see Figure 2). Further, the payroll tax rate for Part A of Medicare has not increased since 1986, when it was set at 1.45 percent each for employers and employees. Since that time, the number of beneficiaries covered by Part A of Medicare has grown from 32.4 million in 1986 to 39 million in 1998, and the share of the U.S. population covered by Medicare has also increased. The payroll tax rate currently is not scheduled to rise in the future.

Promising no new taxes to serve a population that will double over the next 30 years and in which the share of the population will also rise is more wishful thinking than good policy. As a society, we will be substantially better off in the future, but it is likely that the fruits of economic growth will not be shared with seniors unless there are explicit policy efforts to do so. If wages rise just 1 percent a year in real terms, on average, income will be 40 percent higher for a worker in 2025 than today. We will be able to afford substantially more goods and services; the question is how we will share our resources in the future.

Further, Medicare does not offer a comprehensive package of benefits; in fact, this is the way in which Medicare has most failed to remain mainstream insurance. Thus, in addition to pressures to finance the current program, there will likely be a need for improvements in coverage as well.

### **Improved Benefits**

It is hard to imagine a "reformed" Medicare program that does not address two key areas of coverage: prescription drugs and a limit on the out-of-pocket costs that any individual beneficiary must pay. When Medicare was passed in 1965, the benefit package was reasonable as compared to other available private insurance. But over time, private insurance has expanded upon what is covered, while Medicare has changed little.

Critics of Medicare rightly point out that the inadequacy of the benefit package has led to the development of a variety of supplemental insurance arrangements, which in turn creates an inefficient system with most beneficiaries relying on two sources of insurance to meet their needs. Medicaid and employer-sponsored retiree benefits do a pretty good job of comprehensively filling in the gaps. But private supplemental (Medigap) plans -- which serve about one-fourth of all beneficiaries -- are becoming unaffordable for those with average incomes. Costs of policies have risen rapidly as the risk pool becomes more heavily weighted with less healthy beneficiaries (Alexcih et al 1997). Moreover, plans have moved away from community-rated premiums to arrangements where premiums rise dramatically with age. Consequently, these experience-rated Medigap plans shift costs onto those beneficiaries least able to pay.

Further, without a comprehensive benefit package that includes those elements of care that naturally attract sicker patients, viable competition without risk selection among private plans (either in the current Medicare + Choice or its successor) will be difficult to attain. For example, the problems with the current Medicare + Choice system relate more to affording the rising costs of the additional benefits they add to the basic package than to the costs of Medicare-covered benefits. In particular, private managed care plans that have been offering prescription drug benefits find that they attract sicker patients and consequently they have been cutting back on these benefits (Gold et al 1999). If all plans had to offer a basic prescription drug benefit, for example, and payments from Medicare to these plans increased to reflect that new benefit, competition might actually improve.

Thus, a concerted effort to expand benefits is necessary if Medicare is to be an efficient and effective program. The most straightforward approach would be to revise the Medicare package. Alternatively, to make such an expansion to work as a voluntary add-on, a subsidy sufficient to entice even healthy beneficiaries to sign up would be needed.

**Prescription Drugs.** Prescription drug coverage is a logical expansion of Medicare. Drugs are now, more than ever, a critical part of a comprehensive health care delivery system. Lack of compliance with prescribed medications can lead to higher costs of health care over time. And for many who need multiple prescriptions, the costs can be beyond their reach. The private sector, both through Medigap and Medicare + Choice, is failing to fill in the gaps and making coverage less available each year. Thus, to assure future availability, prescription drugs are a crucial -- but expensive -- piece of an expanded benefit package.

**Cost Sharing Changes.** Expansion of coverage to drugs alone is unlikely to be enough to entice enrollees in traditional Medicare to forego supplemental plans since cost sharing under the current program rules can be very high. In particular, the lack of an upper bound limit on what people can owe causes problems. Adopting a more rational Medicare cost sharing package would not have to be extraordinarily expensive if it increased cost sharing in areas that are low now as compared to private plans, while reducing the unusually high hospital deductible and adding stop loss protection (Moon 1996; NASI 2000). Medicare's cost sharing could be brought more in line with what the rest of the population faces without resorting to full first dollar coverage. The difficulty with this approach is that liabilities for cost sharing would rise for many beneficiaries, while the protections would apply to a more limited group (although the amount protected would be substantial), creating more "losers" than "winners." Many of those who would pay more to Medicare could still come out ahead of the current system, however, by not paying the \$1000 or more per year they now spend on Medigap. And as Medigap becomes more expensive, this type of change will become more attractive over time.

**Low Income Issues.** The need to provide protections for low-income beneficiaries has still not been well met by the current system. Income cutoff levels for eligibility for special benefits offered through Medicaid are restrictive, excluding many modest income beneficiaries. Participation in this program is

low, in part because it is housed in the Medicaid program and is thus tainted by its association with a "welfare" program. Further, states, which pay part of the costs, tend to be unenthusiastic about it and likely also discourage participation. Beneficiaries alike in all ways except state of residence may face very different levels of protection.

One advantage of expanding Medicare's benefit package would be an easing of burdens on Medicaid. That might in turn help states that will be struggling to meet the costs of long term care for this population in the future. Improvements in long term care, particularly in home and community-based services are overdue, but likely will only be examined once changes in Medicare have been established.

### **Savings Through Greater Efficiency/Competition**

Efforts to find ways to reduce spending on Medicare have been a high priority for politicians for several years. The urgency behind various reform efforts has diminished, however, as projections of spending growth moderated at the end of the 1990s. And over the long run, Medicare changes in the delivery of care will likely move in tandem with the rest of the health care system, placing limits on what can and should be accomplished with this mechanism.

Nonetheless, several competing approaches to reform remain under discussion. They usually focus on reducing per capita spending and range from incremental changes to major structural reforms to shift Medicare more under the control of private plans. Incremental approaches usually seek to modernize the existing Medicare program, largely by changing payment policies for services and for private plans. Critics of this approach worry that it focuses more on prices charged for services and less on controlling the amount of care being used.

The principal option to restructure Medicare being discussed is a variant of the 1999 plan of the co-chairmen of the National Bipartisan Commission on Medicare's Future. It has since been offered in an amended form by Senators John Breaux (D-LA) and Bill Frist (R-TN). Termed "premium support," this approach would require that beneficiaries choose among an array of private plans (with traditional Medicare being just one choice); if the plan chosen was more expensive than the national average, the beneficiary would have to pay a higher premium. This would presumably result in greater awareness by beneficiaries of the costs of health care and a greater incentive for private plans to hold the line on costs so as to be competitive. Traditional Medicare, which is now effectively the default plan for most persons, would become much more expensive and perhaps would be eliminated over time. This and other proposals to expand competition in Medicare are controversial because they are based more on theory than on practice and many supporters of Medicare are skeptical of the level of savings likely to be generated and fearful of what protections for beneficiaries might be lost if private plans take over.

Recent experience with the Medicare + Choice plan also suggests that we are a long way from being able to rely on the market. Even with payments that should be high enough to cover costs in the traditional program, private plans have pulled out of markets, changed the benefits offered substantially, and have resisted efforts to provide data on quality and to accept adjustments for differences in the risk profiles of beneficiaries. These are not promising trends and suggest that reforms will need to be done at a much slower pace than many would like.

Changes will need to be made in Medicare to keep it up to date, but given the dissatisfaction of many with managed care and the current flux in the delivery system, does putting Medicare beneficiaries in managed care mean keeping up with the times or subjecting beneficiaries to the problem-plagued system the rest of us face? Does managed care in its present form represent an improvement in the delivery of care? Even those who are most enthusiastic about this approach usually admit that it alone cannot solve

the financing problems facing Medicare.

## **Other Reform Issues**

Although most of the current policy attention focuses on proposals to reform the structure of the program and the benefit package, other key issues will also arise as approaches to assure Medicare's future, including age of eligibility, beneficiary contributions, and the need for more general financing. Even after accounting for changes that may improve the efficiency of the Medicare program through either structural or incremental reforms, the costs of health care for this population group will still likely grow as a share of GDP. That will mean that the important issue of who will pay for this health care--beneficiaries, taxpayers, or a combination of the two--must ultimately be addressed. The answer to that question will directly affect whether older Americans will truly be living better in the future.

**Age of Eligibility.** Proposals to raise the age of eligibility for Medicare are offered to reduce the size of the beneficiary population. Life expectancy has increased by over three years since Medicare's passage in 1965, offering one justification for delaying eligibility (NCHS 2000). And if people begin to work longer, delaying their retirement, this option becomes more viable.

About 5 percent of Medicare beneficiaries are aged 65 and 66. If the age of eligibility were increased to 67, however, savings would be substantially less -- likely in the range of 2 to 3 percent of Medicare's overall spending -- since persons in these age groups have lower Medicare costs than other beneficiaries. This is particularly the case since those aged 65 and 66 who became eligible as disabled beneficiaries would stay on the Medicare rolls (Waidmann 1998).

But this approach also has disadvantages. Without private insurance reform, those out of the labor force might find it difficult to obtain insurance. Employers will face higher insurance costs if they provide retiree benefits to fill in the gaps of a rising age of eligibility. Alternatively, they might cut back on coverage, increasing the numbers of persons who would have to pay on their own or go uninsured. As a consequence, if the number of uninsured rise placing burdens on public hospitals, if the costs of producing goods and services rise to pay greater retiree health benefits, if the number of young families supporting their older relatives increase, we will be just as burdened as a society. Thus, we will not have solved anything, although the balance on the federal government's ledgers will improve.

**Beneficiaries' Contributions.** Some piece of a long-term solution probably will (and should) include further increases in contributions from beneficiaries beyond what is already scheduled to go into place. The question is how to do so fairly. Options for passing more costs of the program onto beneficiaries, either directly through new premiums or cost sharing, or indirectly through options that place them at risk for health care costs over time, need to be carefully balanced against beneficiaries' ability to pay. Just as Medicare's costs will rise to unprecedented levels in the future, so will the burdens on beneficiaries and their families. Even under current law, Medicare beneficiaries will be paying a larger share of the overall costs of the program and more of their incomes in meeting these health care expenses (Moon 1999).

One option is an income-related premium where higher income persons 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 have to rise substantially. But more important, such approaches generate only limited new revenues unless the income thresholds are set very low. 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 would not only raise revenue, but also 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.

**Additional Public Financing for Medicare.** Ultimately, the issue of who will pay must be divided between beneficiaries and taxpayers. Even with higher beneficiary contributions and more efforts at improving the efficiency of the program, the long run costs of Medicare will require additional public funds (Gluck and Moon 2000). Since the population currently served by Medicare will grow to more than one in every five Americans, as a society we will need to face up to the costs of financing health care, either through the Medicare program or privately. Reducing Medicare's population or benefits will shrink government liabilities, but do little to change the liabilities that society must face.

## **Conclusion**

Americans living longer will place financial challenges on Medicare and Medicaid to continue to meet the needs of the population. And if seniors are to live better as well, they cannot be expected to bear the full brunt of higher spending requirements for a good health care package. Several steps will be needed in the near future: 1) continuing efforts to improve the efficiency and delivery of care, but probably in incremental steps as the rest of the delivery system evolves, 2) improvements in the benefit package to lead to a situation in which most beneficiaries need only one insurance plan, and 3) expanded financing for the program that asks both beneficiaries and taxpayers to contribute, with the amounts adjusted over time to reflect what each group can afford to pay.

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