

Medicare Reform: Improving Fairness and Efficiency

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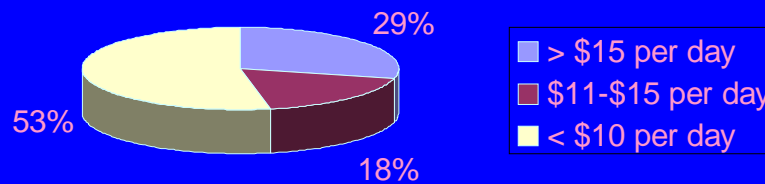
In our other lectures in this series the problem of regional variation in both health care utilization and health care spending has already been introduced. And we raised the possibility that the extra health care in high cost regions might not be beneficial to the Medicare patients living there.

In this lecture two additional themes are developed:

- First; the creation of a Medicare program in 1966 did improve fairness and equity in health care. But today, the question of fairness and equity is much less clear, particularly with respect to geographical variation in expenditures.
- Second; how can Medicare be fixed? In light of our other lectures, including "Unwarranted Variations" and "Is More Better?" we consider a variety of options to improve both efficiency and fairness in the Medicare program.

Maximum Daily Hospital Insurance Coverage, 1961

Source: Hospital Insurance Association of America Survey



In understanding the growth and evolution of the Medicare program, it is important to understand why it was needed. In the early 1960s, it became increasingly apparent that the elderly population suffered from a serious problem of underinsurance. Only one-half of the elderly population had any insurance at all. Even those who had insurance had shockingly low coverage levels. The figure above shows that 53% of those with hospital health insurance in 1961 had coverage that was limited to just \$10 per day! Health care prices were certainly lower in 1961, but there was widespread agreement by 1965 that something must be done to provide the elderly with high-quality health care coverage at minimal cost.



When President Lyndon B. Johnson signed the Medicare bill, there was wide consensus that something needed to be done to provide health care for the elderly. He traveled to Independence, Missouri for the signing, paying homage to former president Harry S. Truman (right) who had been a pioneer in proposing national health insurance.

Medicare

- Part A: Hospital Insurance and (until recently) home health care.
- Part B: Physician and outpatient care (Voluntary, requires a ~\$50 monthly premium to receive coverage)
- Many recipients have “medigap” coverage as well

Medicare is split into two parts, Part A (hospital) and Part B (physician and outpatient care). Part A covers inpatient hospital expenditures and until recently home health care. It is funded entirely by the payroll tax. At the end of 1999, there was \$140 billion in the Part A trust fund, but according to the year 2000 Trustee’s reports, the trust fund is expected to be exhausted by 2025.

By contrast, Medicare’s Part B physician and outpatient insurance is voluntary, in that enrolling requires a roughly \$50 monthly premium to belong. However, it is one of the best deals around, since the premium covers just 25% of the total cost of the program; the remaining 75% is funded through general tax revenue.

About 85% of elderly Medicare enrollees have some kind of “medigap” insurance that pays for components of spending not covered by Medicare. Medigap insurance is provided through private policies or Medicaid.

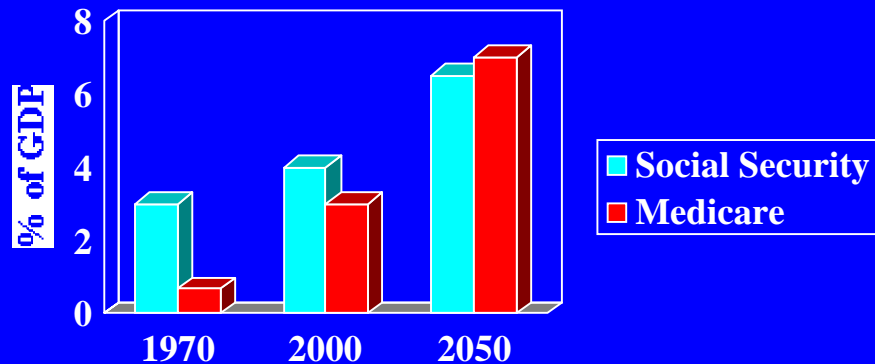
Medicare Was a Success in 1966



- Reduced uninsurance among elderly from 50% to less than 5%.
- Initially, modest costs -- \$3 Part B premium and small payroll tax burden (<\$43 annually)

Most observers agree that Medicare was a tremendous success in the early years. For the first time, the elderly were covered by insurance under a uniform federal program; over the next few decades, the percentage of the elderly population not covered by health insurance would drop from 50% to less than 5%. And when the program started, costs to enrollees and taxpayers were quite modest.

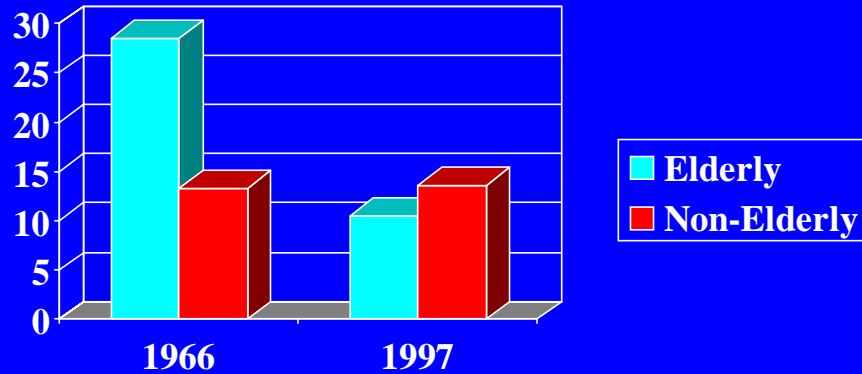
Now, Medicare Is Growing Faster Than Social Security



Since 1966, the Medicare program has grown at a rapid pace. The slide shows Medicare expenditures as a percentage of gross domestic product, or GDP, as measured by the red bars. Under current forecasts of Medicare growth, it is expected to account for 7 percent of GDP, twice as large as its current proportional level of spending. Note also that the Medicare program is expected to exceed Social Security in the next few decades.

The growth in Medicare expenditures has been largely financed through increasing payroll taxes, monthly premiums, and general tax revenue. The Part A trust fund is on schedule to go bust in 2025. Who would shoulder the cost of a more expensive Medicare program? Older households, through the regressive Medicare Part B premiums? Or younger taxpayers, paying more through the payroll tax (paid by rich and poor alike) and general tax revenue?

Poverty Rates by Age, 1966 and 1997



The question of who should pay for the projected Medicare expenditures in the future is critical in thinking about Medicare reform. Back in 1966, the Medicare program was a first step in alleviating widespread poverty among the elderly. As the figure above shows, elderly poverty rates in 1966 were nearly 30 percent, compared to 13 percent for the under age-65 population.

But by the late 1990s, the story had changed. Among the elderly, poverty rates were just over 10 percent, compared to 14 percent among the non-elderly.

Similarly, the percentage of uninsured households is now substantially higher among the under-65 population than among the over-65 population.

In sum, the arguments for transferring *more* resources from younger households to the Medicare program are no longer as persuasive in 2001 as they were in 1966.

Disparities in the Medicare Program

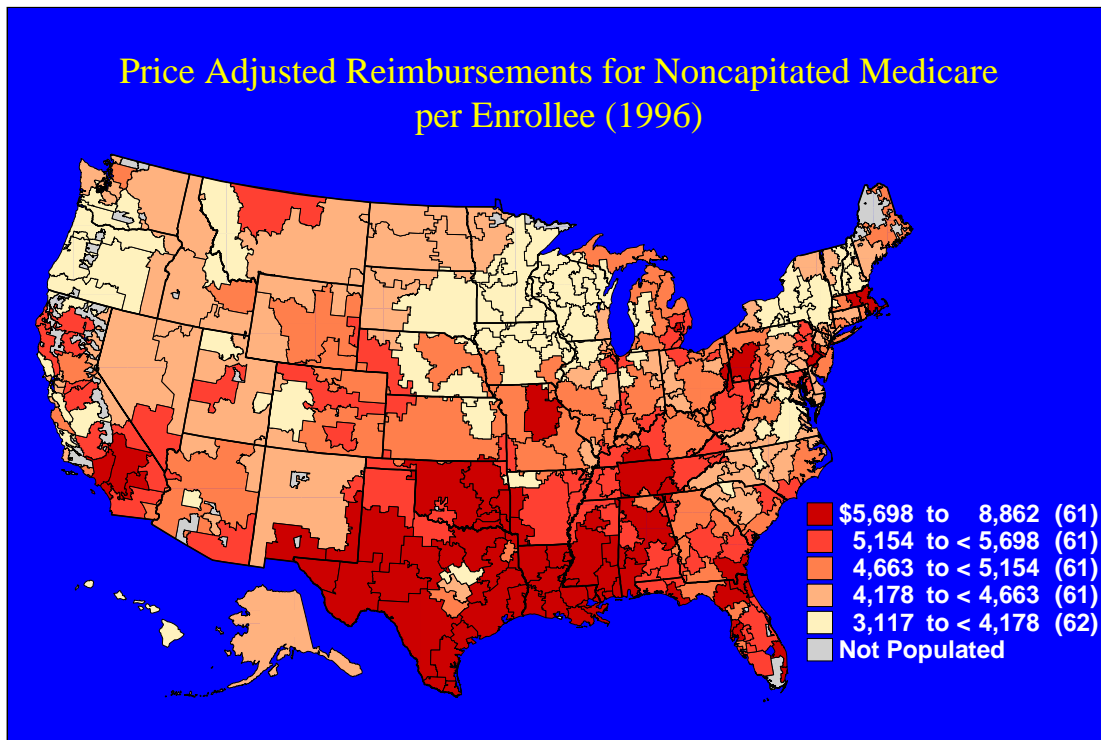
- Inequity can arise according to one's race or income
- Inequity can arise according to where one lives

One problem in the current Medicare program is the presence of inequality in how the benefits are distributed across the elderly. We are not surprised that Medicare expenditures are higher among people with more illness. What is more surprising is how much expenditures differ by race, income, and location among those with similar diseases.

First, there are well known disparities in spending and treatment in the Medicare program by race and income. One recent study found that higher income households received more over their lifetime from the Medicare program. Many studies have shown sharp differences by race in surgical treatment for heart attacks and other diseases.

Second, there is inequality because of where you live. As we argue below, Medicare spending over your lifetime can differ by as much as \$50,000 depending on your state of residence.

Eradicating these sources of inequality in Medicare spending can free up funds to spend on things that people really need and want, such as prescription drug benefits.



We next consider inequality in Medicare according to one's location.

This map is a reminder of the large differences in Medicare spending across regions. In 1996, per capita expenditures ranged from just over \$3,000 to nearly \$9,000. Little of this variation is the consequence of differences in prices or in illness levels.

While informative, this map does not tell us about the *net* variation in Medicare benefits across regions. To do so requires a lifetime perspective, knowing about lifetime levels of benefits, that is, from age 65 onward, as well as taxes paid into the Medicare program during working years.

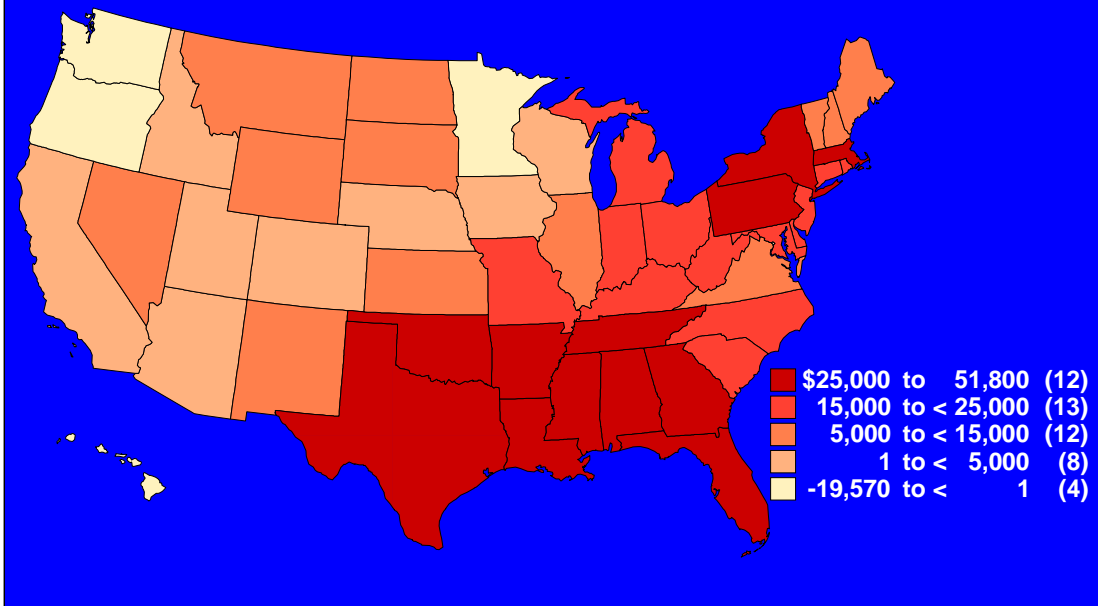
Medicare Transfers Across States: Winners and Losers

Source: Feenberg and Skinner, *National Tax Journal*, September 2000

- *Net Medicare benefits*: Expenditures minus taxes by state of residence (per individual)
- All age groups, all income groups
- Accounts for migration across states

A recent study estimated net Medicare benefits, or expected, and actual benefits, less taxes paid, for each state in the United States. We used Medicare data and tax data to impute average tax payments and benefits across the different age groups represented in each state. As well, we accounted for migration, for example the expectation that a couple working in Minnesota (and paying taxes there) may move to Florida and receive Florida-level Medicare benefits.

Net Lifetime Medicare Transfers



We found remarkable differences in lifetime net benefits across states. Generally, the populations of most states gain under the Medicare program; this is because it is a fairly new program that transfers resources from younger (and ultimately unborn) individuals to older individuals. However, there are some states that gain a great deal, such as Florida, Louisiana, and Texas (more than \$30,000 per person) while other states such as Minnesota and Oregon actually lose money from the Medicare program. In other words, they can expect to pay in more taxes than they can ever expect to receive in benefits.

The Extra Cost (Per Person) of Health Care in Florida Compared to Oregon



These are big numbers. To put their magnitude in context, these results imply that if the federal government were able to reduce permanently per capita expenditures in Florida to levels commensurate with those in Oregon, they could afford to place a brand new Lexus 400 as a 65th birthday present for every resident of Florida, for ever. When Lyndon Johnson oversaw the first few years of Medicare, the dollar amounts were low and relative differences in spending were just not that important. Now, the magnitude of Medicare spending is large enough that the opportunity cost (that is, how the money could have been spent otherwise) is enormous, and should force Americans to think carefully about whether they are getting their money's worth from the Medicare program.

How to Explain These Differences in Medicare Expenditures

- (A) Elderly people in high-expenditures areas enjoy better (incremental) health. Not fair

There are a variety of ways to explain these differences in spending. We consider each in turn, and point to the one that seems most likely.

One is that the high-expenditure regions reap real gains from all of this spending, and as a consequence enjoy better health. But then the Medicare program really is not fair; why should residents of Florida live incrementally longer than residents of Oregon?

How to Explain These Differences in Medicare Expenditures

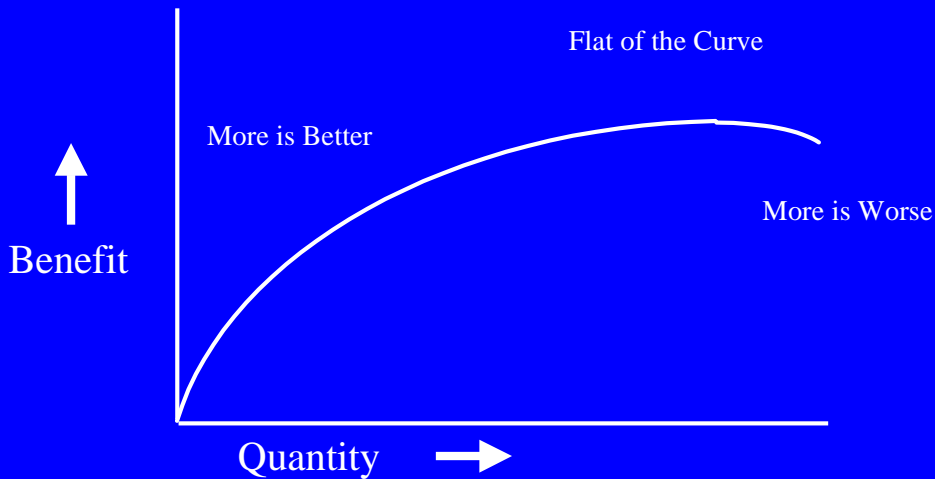
- (A) Elderly people in high-expenditures areas enjoy better (incremental) health. *Inequitable*.
- (B) Marginal expenditures yield no net health benefit. *Inefficient*, but not all that unfair

The second possibility is that the higher levels of spending in regions such as Miami yield no net health benefits to enrollees. In this case, the problem is not so much inequality -- since people in the high cost areas aren't any better off than those in low cost areas -- as much as inefficiency, by which I mean wasted resources.

Of course, under this second possibility, the Medicare program is still unfair with respect to Medicare managed care enrollees, whose capitation fee is based on the prevailing county-level fee-for-service costs. Thus, managed care firms in the Miami area receive roughly twice as much per enrollee as those in Minneapolis, allowing them to provide more in services to HMO residents of Miami.

A final issue is equity with respect to working-age taxpayers (under age 65) who are ultimately paying for all of the extra care in high-expenditure regions.

Critical Question: What Does the Extra Spending Buy?



As we have discussed in the lectures on “Unwarranted Variation” and “Is More Better?”, the most likely explanation for the differences in spending across states and regions is (B), the extra spending yields no net incremental health benefits. This corresponds to the “flat of the curve” region on the graph above, where more spending does NOT buy any benefits. In fact, in “Is More Better?”, it is shown that we are even further to the right, in the region of “More is Worse.”

What should be done? In the following slides, we consider a variety of policy reforms for Medicare to encourage a more efficient and equitable health care system at lower overall cost.

How to Reform Medicare

- Improving Quality of Care Across Regions
- Improving the Quality of Medical Decision Making
- Reducing Disparities in Expenditures Across Regions

Here we consider three general groups of reforms to improve the Medicare program. The first, reported in “Unwarranted Variations”, relates to improving quality of care, by which we mean the underuse of effective care. The second relates to improving the quality of medical decision making, in other words ensuring a good match between what patients want and what they get in treatment. And the final topic, and in some respects the hardest, is how to reduce the disparities in expenditures across regions.

How to Reform Medicare

- Improving Quality of Care Across Regions

The first topic is how to improve quality of care, in particular ensuring that effective care is not underused. In “Unwarranted Variations” we saw there was widespread underuse of clinically effective care. Integrated health systems such as staff and group model health maintenance organizations have proven their ability to deliver effective care to almost all of their enrollees, although they are losing market share to less tightly structured health plans.

How can quality standards be maintained in the fee-for-service population? One approach would be to use the Medicare claims data to track physician groups or hospital staff to provide rapid feedback on the quality measures such as mammography rates or Hemoglobin 1ac tests for diabetics. The advantage of this approach is that the measures are readily available and simple to calculate. Another possibility is the use of more sophisticated quality outcome measures for specific hospitals or hospital staffs, but research on their reliability and feasibility is still in its infancy.

How to Reform Medicare

- Improving Quality of Care Across Regions
- Improving the Quality of Medical Decision Making

It is important to understand that even if the broad population-based measures of procedure use are similar across regions -- i.e., that regional variation has been erased -- that this does not imply efficiency in health care. Instead, what we term allocative efficiency will not be satisfied unless the right patients are matched with the procedures they prefer.

To see this, consider an example of women with breast cancer who are choosing between two options, a radical mastectomy or breast-sparing surgery, a lumpectomy followed by radiation therapy.

Example of Mismatch of Preferences

ID	Doctor	Patient's Preference	Actual Treatment	Match?
1	A	BSS	RM	No
2	A	RM	RM	Yes
3	B	BSS	BSS	Yes
4	B	RM	BSS	No
5	B	BSS	BSS	Yes

RM = Radical Mastectomy, BSS = Breast Sparing Surgery

Consider this simple example. There are five women in this hypothetical region, numbered one through five in each of the Table rows above. There are two doctors. Patients one and two see Doctor "A", while patients three through five see Doctor "B."

Among these five women, three would prefer to have breast-sparing surgery (BSS), that is, lumpectomy followed by radiation therapy (patients one, three, and five) while two would prefer radical mastectomy (RM) (patients two and four). Therefore, the "right rate" for breast sparing surgery in this region is 3/5 or 60 percent.

As it happens, Doctor A is a strong proponent of radical mastectomy (RM), while Doctor B is a strong proponent of breast-sparing surgery (BSS), so the first two patients receive RM and the next three patients receive BSS. At the population level, the rate is exactly the right one -- 60 percent. The problem is that the wrong people are being treated, so there is still substantial inefficiency in the delivery of care.

Making Sure that Patient Choice Matters

- Tying the use of shared decision making tools for discretionary patient choices to Medicare reimbursements
- Further research on understanding patient preferences

Outcomes research and shared decision making have been proven effective in reducing unwarranted variations in discretionary surgery, yet these remedies are applied only sporadically. Tying Medicare reimbursement rates to the use of such shared decision making tools would both improve the match between patient preferences and patient choices, as well as potentially saving money for the Medicare program through lower rates of intensive (and expensive) treatment options.

We are just beginning to understand the way that patients make decisions, and how we can improve the quality of decision making. Additional research to better understand patient preferences and choices is critical to improve the efficiency of the Medicare program.

How to Reform Medicare

- Improving Quality of Care Across Regions
- Improving the Quality of Medical Decision Making
- Reducing Disparities in Expenditures Across Regions

It is in the third category of savings, unwarranted variations in spending, that the potential savings are greatest. Here we consider both the potential benefits from such savings, as well as concrete proposals to effect such savings.

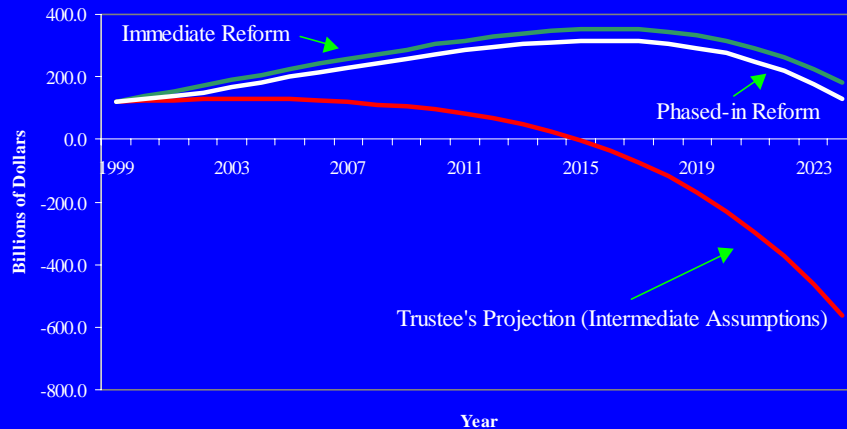
The Benefits From Reducing Regional Disparities in Medicare Spending

- Financial Viability of the Medicare Trust Funds

There is concern that the Medicare trust funds will be exhausted before many baby boomers even reach retirement age. Regional disparities are sufficiently important financially so that their reduction would have an enormous impact on the financial stability of the Medicare program.

Medicare Trust Fund Projections

Source: Skinner and Wennberg, 2000a



In an earlier study, we have considered the budgetary implications for the Medicare trust funds, of scaling back expenditures in the high cost regions to those commensurate with the lower cost areas, after adjusting for differences in illness and price levels. We then used the intermediate Trustee's projections to evaluate the impact of such a reform on predicted trust fund balances.

The bottom (red) line shows the imputed Trustee's projections which (at the time) showed the funds going bust around 2015. (Rosy economic projections have since pushed that date further along). The green line shows the projected balances of the Medicare trust funds under the assumption that Medicare expenditures are reduced in 2000; the white line assumes a more graduate phase-in period. Both show the enormous financial benefits of scaling back Medicare benefits in the high-cost regions, with a balance of \$200 billion instead of the projected shortfall of -\$600 billion in 2024. Whatever the current Trustee's projections, we expect this reform alone to extend the life of the Medicare trust fund by a decade.

The Benefits From Reducing Regional Disparities in Medicare Spending

- Financial Viability of the Medicare Trust Funds
- Pay for insurance coverage (e.g., prescription drugs) that people actually want
- Reduce tax burden on low income working population

There are other potential uses for the money saved, such as prescription drug coverage without recourse to increasing premiums or taxes.

Savings in Medicare expenditures could also take the form of tax relief to the lowest income working population. The Medicare payroll tax is proportional to earnings, and regressive with regard to overall income. This is because earnings are a smaller fraction of total income for high income households.

The combined payroll tax for Social Security and Medicare is about 14 cents per dollar of earnings (including both the employer and employee share) from the very first dollar earned. Scaling back these payroll taxes would offer a greater proportional tax relief to lower income working households than similar proposals under consideration by the Bush administration.

How to Cut Back in High Expenditure Regions

- Cutting back on capacity (a) Hospital Beds

One long-term approach is to reduce the supply of resources. For example, per capital hospital beds are easily measured at the regional level, and it is straightforward to benchmark regional hospital bed capacity with appropriate adjustments for differences across regions in illness levels. Hospitals would be more willing to reduce capacity with appropriate financial incentives from Medicare and other large providers. Reducing capacity however, is likely to face serious political opposition from those who believe that any cutback in the quantity of care means a cutback in quality of care. Such fears serve the financial interests of providers, who are likely to try to reinforce them.

A better understanding of how hospital capacity and greater intensity affects quality of life for those with chronic and life-threatening disease – increased use of mechanical ventilators, painful diagnostic testing, and the risk of dying in an ICU – might create popular consensus for limiting the intensity of inpatient care.

Recent trends in Oregon suggest that public discourse on the benefits and harms of a more intensive practice style can support substantial reductions in hospital capacity and use.

How to Reduce Costs in High Expenditure Regions

- Cutting back on capacity (a) Hospital Beds
- Cutting back on capacity (b) Physicians

The supply of physicians has been encouraged through federal subsidies to medical schools and residency programs. It was once thought that increasing the supply of physicians would lower the price of health care and encourage more to settle in under served areas. Neither objective has come true. It is hard to justify continuing those subsidies unless they can be targeted to improving access to care in under served areas.

How to Reduce Costs in High Expenditure Regions

- Cutting back on capacity (a) Hospital Beds
- Cutting back on capacity (b) Physicians
- Vouchers tied to national benchmarks

Another option for reducing regional spending differences comes from the use of insurance premium support for Medicare enrollees, as suggested in the Breaux-Thomas committee report. Under the insurance premium support program, Medicare enrollees would be given a voucher that would be worth a given dollar amount, and could be used to purchase coverage from private insurance carriers.

A voucher program tied to regional differences in spending would certainly make transparent Medicare's cross-region redistribution. Over time, the voucher amount in high expenditure regions could be adjusted to reduce regional disparities, with the ultimate goal of setting the (illness adjusted) premium support to a level commensurate with the low cost regional medical expenses. Such a program could clearly effect the \$40 billion annual saving, but the political pressure from both elderly enrollees and providers could be heated.

How to Reduce Costs in High Expenditure Regions

- Cutting back on capacity (a) Hospital Beds
- Cutting back on capacity (b) Physicians
- Vouchers tied to national benchmarks
- Selective contracting by Medicare vendors

Selective contracting is another approach to Medicare reform. Under selective contracting, only hospitals or physicians that follow quality guidelines and resource use guidelines would be eligible for billing at a preferred rate. Selective contracting provides a powerful lever by insurance institutions and large firms to set quality standards for providers

Summary

- Medicare made great strides in improving fairness and health care coverage in its early days.
- The picture is more clouded today, particularly with respect to disparities by race, income and location.

There is no question that the introduction of the Medicare program in 1966 improved access to health care for the vast majority of the U.S. elderly population. Keeping those benefits in mind, we have taken a closer look at how the vastly more expensive Medicare program today improves fairness and equity. Unfortunately, we have found in many cases evidence that disparities permeate the Medicare program, both with regard to race and income, and especially with regard to location.

Summary

- Medicare made great strides in improving fairness and health care coverage in its early days.
- The picture is more clouded today, particularly with respect to disparities by race, income and location.
- Reforms can improve quality of care, reduce disparities, and improve the financial health of Medicare.

A variety of reforms appear to us to represent “win-win” situations in which quality of care is improved without additional costs. These include quality monitoring and shared decision making to empower patients in their choices of health care options.

We believe that these approaches to improving the quality of care should also improve access to care among minority and poorer elderly, ensuring that each elderly person is receiving the best available care.

The gains from reducing disparities in Medicare expenditures are too large to be ignored. The goals are not unreasonable: after all, large metropolitan areas such as Minneapolis and Portland Oregon are getting along just fine with relatively modest Medicare expenditures. The problem comes in implementing the savings.

We have suggested a variety of reforms that focus on both the longer term, through hospital and physician supply, as well as the shorter term, through nationally benchmarked vouchers, and selective contracting.

We believe that these reforms will improve both, the financial health of the medicare program, as well as ensure the healthcare of the US elderly population.