

# Comment on “Medicare Benefits: A Reassessment”

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**A**S WITH EVERY ISSUE WHICH IS ON ITS AGENDA, Congress can consider the reform of Medicare from a narrow or a broad perspective and can respond through modest or far-reaching action.

In addition to the obvious fact that Medicare will face a financial crisis in the years ahead, it has other serious shortcomings: it does not provide insurance for catastrophic illness; long-term care, a major need of the frail and sick elderly, is not covered; the proportion of the health care costs of the elderly that Medicare covers has declined since the beginning of the program to a point where it accounts for less than half of their total outlays for medical care. About two-thirds of all Medicare beneficiaries buy medigap insurance to protect themselves against the high deductible items and other forms of cost-sharing mandated by Medicare. Medigap, which has a high loading cost, probably contributes to the overuse of scarce resources by discouraging patients and their physicians from pursuing less costly but efficacious forms of treatment. And until recent congressional amendments—the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and diagnosis-related groups (DRGs)—to the preexisting system, Medicare’s reimbursement policies surely contributed to steep acceleration of hospital costs.

In light of the foregoing catena of shortcomings, the approaching financial crisis might be viewed by Congress as an opportunity to undertake a radical restructuring not only of Medicare but of our total health care system. I am convinced that such an effort would be misguided and would surely fail.

Let me briefly explain why I have reached this conclusion and why I believe that Congress would be well advised to focus largely, perhaps exclusively, on the one problem that it must address, the prospective large deficit in the Medicare trust fund, at the same time that it seeks to reduce general revenue support for Supplemental Medical Insurance (SMI). The following brief review is a reminder of earlier efforts to improve and reform Medicare.

Since 1972 there have been repeated federal legislative and administrative actions aimed at slowing the rise in hospital costs, the key element in Medicare expenditures, accounting for about 70 percent of its total outlays. There is only one way to read this record: We have had little success in containing the rise in costs. The most that can be said for more than a decade's efforts is that, without them, the increases would have been still greater. We are just starting on a new, much more radical effort, the DRG approach. The better part of wisdom would be to give this initiative a chance to show what it can do. DRG may not work and it surely won't work without adjustments down the road as the full import and impact of prospective reimbursement are revealed. But if Congress, in responding to the looming financial crisis that confronts Medicare, were to introduce additional changes, it would almost certainly doom the DRG system before it has a chance to demonstrate its potential for reducing the rate of hospital cost increases.

It is a decade since Congress decided to make federal funding available to accelerate the growth of health maintenance organizations (HMOs) in the hope and expectation that they would be able to contain health care costs. However, the rules and regulations were drawn so tightly that growth was inhibited; even after the regulations were relaxed, HMOs have grown relatively slowly, and with regard to enrolling Medicare beneficiaries on a prepayment basis, the record of the HMOs to date is close to nil. HMOs are simply not able or willing to risk adverse selection.

During the same period, there has been a proliferation of alternative health care delivery systems and the years ahead will see many more.

But it would be an error to exaggerate the speed with which the extant system of fee-for-service medicine, private sector Blue Cross-Blue Shield and commercial insurance, the increasing technological sophistication of nonprofit acute hospitals, and the academic health centers are changing or will change.

More than six years ago Alain Enthoven first recommended to the secretary of Health, Education, and Welfare that the basic structure of the U.S. medical care system be altered through greater reliance on the "competitive market." His was the most far-reaching proposal advanced to change the existing incentives which determine the behavior of both consumers and providers. He hoped to accomplish the following: to improve efficiency through more appropriate treatment modalities; to assure broad access to health care for the poor; to reduce federal outlays; to provide insurance for catastrophic illness; and much more. All of these benefits, he maintained, would be obtained at a considerably reduced total cost. His cogently written proposal had one major flaw: He did not explain how or why the key interest groups—physicians, academic health centers, trade union members, and the elderly—would embrace "competition" if their losses were certain, their gains problematic.

The foregoing abbreviated account suggests that it is much easier for analysts to outline on paper the design of a much improved health care system than for Congress to legislate the reforms to effect it. It is just possible that the extant Medicare system, while far from perfect, has been performing reasonably well, which is all that one can expect in this imperfect world. It has brought the elderly into the mainstream of American medicine. Their access to health care has been much expanded. They are reasonably protected against high bills for acute hospitalization. They are being treated by physicians who, because of advances in knowledge and technology, can do more for them by adding to both the quality of their lives and their longevity.

Since the expenditures of the Medicare program have risen much more rapidly than anticipated, and the total costs for health care are now at 10.5 percent of the GNP and continuing to rise, the federal government must shore up the Medicare trust fund. This is the principal challenge that Congress confronts. The public is not asking Congress to alter in any radical fashion the Medicare system as it has evolved; it is even less interested in its restructuring the entire health care system. Although many are concerned about the steeply rising

health care costs, there is no political consensus for major Medicare or total health care reform.

### The Hsiao-Kelly Proposal

In light of my reading of our experience with Medicare, I will now comment briefly on William C. Hsiao's and Nancy L. Kelly's paper, "Medicare Benefits: A Reassessment." Their proposal is at once too ambitious and not ambitious enough. It deals with possible ways of helping to close the financial gap that lies ahead, but its recommendations go only a small distance in this direction—a \$3 billion contribution toward closing the gap by 1987. At the same time the authors recommend the introduction of a major new benefit—"catastrophic coverage." Further, they contend that their detailed proposal, if implemented, would lead to desirable changes in the actions of both beneficiaries and providers which would contribute to the more efficient use of health care resources and this in turn would be reflected in lower costs.

Any new costly benefit such as catastrophic coverage seems to me to be contraindicated at a time when the prospective trust fund deficit may approach or exceed \$300 billion by 1995. The issue of catastrophic insurance has been on and off the congressional agenda for many years, but even when the financial situation of Medicare and the federal government was much more favorable than at present, the key committees declined to mark up a bill. If they had reasons to hesitate in the late 1970s, they have much better reasons to delay in the mid-1980s. I agree with the authors that in theory any broad insurance plan should include catastrophic coverage. For better or worse, however, the American public has defined medical insurance not as a system of protection against financial ruin, but rather freedom from having to pay out of pocket for large medical bills. Since the public has repeatedly demonstrated that it is not willing to copay more, to add coverage for catastrophic illness appears at this time to be ill-advised.

Moreover, I question the emphasis which the authors place upon those facets of their proposal aimed at changing the behavior of both consumers and providers. If one starts with the premise that most Americans have an ongoing relationship with a physician whom they trust, and whose advice they generally follow, and further that they

have coverage that protects them against large bills, there is little room for incentives based on price to come into play. Similarly, while long-term changes in the number of physicians can affect their fee schedules and how they practice, the established members of the profession have considerable scope at present and in the near and middle term to continue more or less in their accustomed ways. Over time the new entrants into the profession will have to adjust to a more crowded market and will be under pressure to join an alternative delivery system or accept salaried positions. But one must not assume that if these shifts occur total costs will be constrained. I doubt that they will be.

With regard to hospital care, patients follow their physicians' advice both as to admission and treatment. The DRG system looks to price competition to slow costs, but whether it will succeed remains to be seen. Finally, alternative delivery systems focused on price will have some effect on the present system but it will be slow. I would give relatively little weight to the authors' anticipation of major efficiency gains; prices alone cannot alter fundamentally a market in which consumers pay out of pocket only about 30 percent of all charges and, in the case of hospital care, less than 10 percent. Since most consumers have broad insurance coverage and since physicians are wedded to fee-for-service, price competition will not bring about significant efficiency gains. Only a radical restructuring of the entire system, such as Enthoven envisaged, which neither a Democratic nor a Republican administration was willing to try, could provide the market test which the authors favor.

I do not believe that Congress should attempt to modify the Medicare system by placing a sizable copayment on most patients who use hospitals between the second and the sixtieth day. That would be a major "take-back" from the elderly, half of whom have very modest incomes, no more than twice the poverty level.

My primary objections to the authors' proposal, therefore, are fourfold: It provides too little relief for the financial situation facing Medicare; it offers a new and costly benefit, that for catastrophic illness; it suggests, mistakenly, in my opinion, that there will be large efficiency gains that will moderate the rise in costs; it ignores the violation of the "social contract" by reducing substantially the benefits that Medicare has provided beneficiaries up to the present.

I have a series of second-order objections which I will briefly note.

I see no way of establishing and operating a threefold classification system of providers, physicians, and hospitals, based on their relative charges, and gearing copayments accordingly. The administrative and legal complications of shifting classifications in a rapidly changing marketplace would be horrendous, and the realignments in patient-physician and physician-hospital relations would either not occur or, if they did, the ensuing costs would be very large. I consider it bad public policy to encourage patients to seek medical care guided by unit price; the much more relevant considerations should be safety and long-term effectiveness.

Further, it may be misleading to provide a figure of \$120 as the average additional cost per beneficiary. Only 1 in 5 of the elderly is hospitalized in any one year, and there is a high probability that those admitted will have a second hospitalization during the following year. Accordingly, the potential costs should be calculated not in terms of all beneficiaries, but for those who require hospitalization. The costs to the latter would be many times the average figure for all beneficiaries.

Finally, the authors assume that the preference for medigap policies would be reduced by the expansion of Medicare coverage under their proposal to include protection against catastrophic costs. From what was said earlier, I doubt that many beneficiaries would forego this protection. In that event, the so-called behavioral changes aimed at cost-containment on the part of providers would be problematic.

I believe that the major contribution of the Hsiao-Kelly proposal is to alert the Congress to move with great circumspection before it decides to legislate any broad-based reforms for Medicare.

### A Few Modest Suggestions

Congress should focus its attention on finding new sources of income for the trust fund. Other papers will address the issue of Medicare revenues and consider in detail the underlying social principles and a broad array of pragmatic approaches. My own preferences are for increasing the tax rate on hospital insurance (HI), introducing a premium geared to income for beneficiaries of SMI, and the imposition of higher excise taxes on liquor, cigarettes, and other known pathogenic substances.

In addition, Congress should explore possible contributions to slowing

the rate of increase of health care costs without depriving beneficiaries of significant current benefits. For example, there is widespread agreement among knowledgeable persons that the rapid and continuing introduction of new technology has been a major contributor to a steady and steep rise in health care costs. An advisory commission under professional leadership might help to slow the acceptance of new costly procedures until they have demonstrated significant therapeutic value.

Too little is known about the 1 percent of all patients who account for 30 percent of all medical expenditures, up from 17 percent in the period just before the passage of Medicare and Medicaid. The presumption is that if we understood the reasons back of these very large expenditures, some alternative, less costly, therapeutic approaches might be used.

One concluding comment: I do not believe that all of the foregoing, even if aggressively pursued, will prevent health care costs from continuing to increase as a percentage of the GNP. But to interdict such a rise is not the challenge that Congress faces, nor is it one that Congress has the capacity to resolve. The federal government accounts for over one-quarter of all health care expenditures, a significant proportion but not enough to leverage the system. At some point down the road the other major participants may become so unnerved by the continuing rise in total health care expenditures that they may seek new federal legislation aimed at restructuring the system. At that point, Congress will be better positioned to act. Until that time, it should find a solution for the difficult but much less complex issue of keeping Medicare financially viable.

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