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## Modernizing Medicare's Benefit Structure

Marilyn Moon

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# Modernizing Medicare's Benefit Structure

Marilyn Moon\*

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## *I. Introduction*

Senator John Breaux has referred to the Medicare program as a "65 Chevy."<sup>1</sup> While this characterization is not necessarily an apt description in many areas, it is certainly true in terms of the structure and composition of the benefit package. The cost-sharing pieces of Medicare established by Congress in 1965 were an ad hoc collection of requirements that resulted from political

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\* Vice President and Director of Health Programs, American Institute for Research. Additional funding for this analysis came from the Commonwealth Fund.

1. John Breaux, *Save Medicare from Itself*, BLUEPRINT, Spring 2000, at 54, 56.

horse-trading and concerns about limiting the program's costs.<sup>2</sup> Parts of the program looked very much like the private insurance of the time.<sup>3</sup> Despite general agreement since the 1970s that the benefit structure should be improved to reflect changes in the needs of Medicare beneficiaries and the evolution of private insurance over time, a major overhaul of the benefit package did not take place until December of 2003.<sup>4</sup>

In part, the lack of progress is due to a major disagreement of whether changes should only come in the context of broader reforms.<sup>5</sup> But, rather than tackle that issue head on, this Article assumes that, regardless of other reforms, an improved benefit package is needed and that no insurance arrangement is likely to succeed without such changes. Further, defining an appropriate benefit package is an important part of any debate regarding how much flexibility to allow if private plans are to be the future of Medicare: Which benefits are essential and which could be allowed to vary? Thus, benefit improvements represent a first step and one that can be separated from the broader discussion.

## II. *Why Focus on Changes In Cost-Sharing and Benefits?*

Negotiations between the House and the Senate in 1965 created the basic structure of the Medicare program with its large variety of benefits and patchwork of limitations and definitions.<sup>6</sup> The outcome of the negotiations was a complicated structure of hospital benefits with co-insurance days, lifetime reserve days, and a spell of illness concept that led to the potential for multiple hospital deductibles in a given year.<sup>7</sup>

Changes over time have exacerbated the problems of the benefit structure. For example, when Congress introduced Medicare, it set the deductibles for

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2. See generally, e.g., THEODORE MARMOR, *THE POLITICS OF MEDICARE* (2d ed. 2000) (describing Medicare's political history); ROBERT J. MYERS, *MEDICARE* (Richard D. Irwin ed., 1970) (same).

3. See MYERS, *supra* note 2, at 87–89 (describing the general structure of Medicare).

4. See generally MARILYN MOON, *MEDICARE NOW AND IN THE FUTURE* (2nd ed. 1996) (describing the static state of Medicare).

5. John Breaux, Senator for Louisiana, *Breaux Reacts to Details of White House Medicare Plan*, Press Release, at <http://www.senate.gov/~breaux> (last visited Jan. 10, 2004) (praising the White House plan as an "important first step" while advocating "comprehensive Medicare reform") (on file with the Washington and Lee Law Review).

6. See MYERS, *supra* note 2, at 55–63 (detailing the history of the 1965 Medicare legislation).

7. See *id.* at 100–27 (summarizing the coverage benefits of the 1965 Medicare legislation).

Part A and Part B<sup>8</sup> at nearly the same level: \$40 and \$50, respectively.<sup>9</sup> Over time the Part A deductible has grown enormously, to \$840 in 2003, compared to just \$100 for Part B.<sup>10</sup> Although the Part B premium was reduced from 50% to 25% of the costs of Part B services, the share of Medicare covered by Part B has grown substantially, thus keeping the share that beneficiaries pay of the full costs of Medicare through a premium nearly constant.<sup>11</sup>

In addition to problems with cost-sharing, the scope of the benefit package is widely recognized as inadequate. In particular, Congress omitted drugs, although there was considerable discussion even in the late 1960s of the importance of adding drugs to the benefit package.<sup>12</sup> Moreover, prescription drug coverage became more of an issue in the 1990s as the lack of drug coverage led to inefficient use of care. For example, when doctors prescribe drugs, but patients fail to use them, the patients' health conditions may worsen and increased hospitalizations can occur.

Overall, Medicare's benefits cover just a little over half of the costs of acute care for the eligible population, making this program less generous than over 80% of private insurance policies.<sup>13</sup> As a result, on average, beneficiaries now devote over 22% of their incomes for premiums and direct costs each year (not counting costs of institutionalization).<sup>14</sup> Thus, prescription drug coverage is crucial to beneficiaries. As Figure 1 indicates, costs for Medicare beneficiaries stem from a range of sources—not just drug expenditures or Medicare cost-sharing. The costs that individuals bear from private supplemental insurance are substantial.<sup>15</sup>

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8. Part A hospital insurance covers inpatient and some postacute care while Part B supplemental medical insurance covers physician and other ambulatory services and outpatient hospital care.

9. Hospital Insurance of the Aged and Disabled, Pub. L. No. 89-97 § 1813(b) (1) (1965).

10. See THE BDS. OF TRS., THE ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTAL MEDICAL INSURANCE TRUST FUNDS 120 (2003) (providing a table of historical premium amounts).

11. See *id.* at 65-67 (providing tables of premiums and costs of Part B). In 1966, Part B represented about one-fourth of overall Medicare spending and hence the Part B premium constituted 12% of Medicare spending. *Id.* In 2003, the Part B premium was 25% but it was applied to a much larger base of 40% of total spending. In that case the premium covers about 10% of overall expenditures. *Id.*

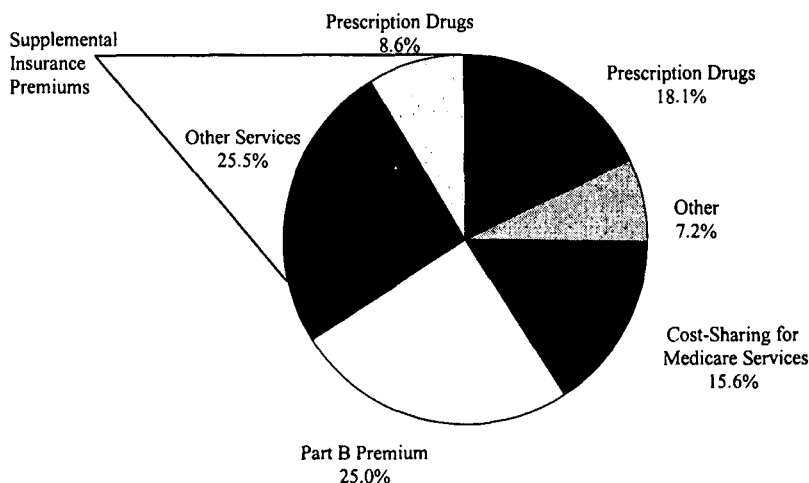
12. MYERS, *supra* note 2, at 55-63 (detailing the history of the 1965 Medicare legislation).

13. KAISER FOUND., MEDICARE CHART BOOK 46 (1997).

14. STEPHEN MAXWELL ET AL., MODERNIZING MEDICARE COST SHARING: POLICY OPTIONS AND IMPACTS ON BENEFICIARY PROGRAM EXPENDITURES viii (Commonwealth Fund, Pub. No. 571, 2002).

15. See *id.* at 9-11 (detailing the costs for Medicare beneficiaries).

**Figure 1**  
**Distribution of Out-of-Pocket Expenditures**  
**Among Elderly Medicare Beneficiaries, 1999**



Source: Urban Institute analysis of the 1999 MCBS  
 Note: Excludes HMO, ESRD, and Facility beneficiaries

The inadequacy of benefits creates other problems as well. Most beneficiaries obtain protection through supplemental policies that vary dramatically in quality and comprehensiveness.<sup>16</sup> This discrepancy complicates two goals: improving the benefits package and helping beneficiaries cope with health care needs. Furthermore, supplemental insurance (known as Medigap) increases healthcare costs and the expenditures of beneficiaries but adds little to their well-being.<sup>17</sup> Figure 1 indicates that Medigap is a major source of out-of-pocket expenses. The administrative costs and other expenses for this insurance are very high, and when added to the actuarial costs of the benefits, Medigap may actually increase beneficiaries' overall out-of-pocket burdens.<sup>18</sup>

16. Laschober et al., *Trends in Medicare Supplemental Insurance and Prescription Drug Coverage*, HEALTH AFF., (Feb. 27, 2002), available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.127v1.pdf>.

17. See Joseph Antos and Linda Bilheimer, *The Bumpy Road to Reform, Medicare in the Twenty-First Century*, in MEDICARE IN THE TWENTY FIRST CENTURY 24, 31–32 (Robert Helms, ed. 1999) (describing proposed supplementary coverage proposals); MOON, *supra* note 4, at 11–12 (discussing the costs of supplemental insurance).

18. See MAXWELL ET AL., *supra* note 14, at 14–15 (comparing the effects that Medigap and cost-sharing proposals would have on out-of-pocket expenditures).

At most, Medigap offers beneficiaries the benefit of spreading out their expenses so that they are not inordinately high in any given year.

Beneficiaries do not benefit if returns simply shift out-of-pocket expenses from one category to another in a cost-neutral way. But, avoiding this result would require additional contributions from taxpayers—only a limited amount of which will likely occur in an environment of substantial sensitivity to the size of Medicare's public spending.<sup>19</sup>

Beyond creating direct savings through patient contributions, the intent of cost-sharing is to provide cost awareness and thus give beneficiaries incentives to make careful use of services.<sup>20</sup> If done well, this approach can lower use, rather than just rely on cost-sharing as a way to reduce public burdens. But, how the type of healthcare service determines the importance of these incentives varies by the type of healthcare service. In Medicare, cost-sharing requirements are out of balance. The deductible of \$100<sup>21</sup> is very low given that it could be raised to \$250 or \$300 per year and still be comparable to or lower than that found in many private insurance plans.<sup>22</sup> Medicare's hospital deductible (and co-insurance), in contrast, is extraordinarily high.<sup>23</sup> In practice, few advocates of cost-sharing argue that hospital deductibles or co-insurance succeed in discouraging overuse of services because patients rarely make the decision to check into a hospital on their own.<sup>24</sup> Thus, if Congress uses cost-sharing as more than just a tool for passing on a greater share of the costs to beneficiaries, then reduction in hospital cost-sharing would be appropriate.<sup>25</sup>

Further, because supplemental coverage often eliminates much of the cost-sharing, it reduces or eliminates much of the incentive to hold down use of

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19. *Medicare: New Spending Estimates Underscore Need for Reform: Hearing Before the House Comm. on the Budget*, 105th Cong. 19 (2001) (statement of David Walker, Comptroller General of the U.S., Government Accounting Office).

20. *See Medicare Cost-Sharing: Implications for Beneficiaries, Testimony Before the House Ways and Means Subcommittee on Health*, 108th Cong., 2003 WL 2008102 at \*18 (May 1, 2003) (statements of Patricia Neuman, Vice President and Director of the Medicare Policy Project, Kaiser Policy Project, and the Henry J. Kaiser Family Foundation) (discussing Medicare's cost-sharing system).

21. 42 U.S.C. 1395(f)(b) (2003).

22. *See, e.g.*, THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY 90–95 (2003) (providing data on the deductibles of private insurance).

23. *See* Department of Health and Human Services Notice: Inpatient Hospital Deductible and Hospital and Extended Care Co-insurance Amounts for 2003, 67 Fed. Reg. 64,641, 64,642 (Oct. 21, 2002) (setting the inpatient hospital deductible for the Medicare program at \$840 and the daily co-insurance amount for the 60th to 90th day of hospitalization at \$210).

24. MOON, *supra* note 4, at 146.

25. *Id.*

care.<sup>26</sup> One goal of improved coverage should thus be to eliminate or at least substantially reduce the need for supplemental coverage. Having just one insurance plan would simplify bill paying and financing issues for beneficiaries. Further, a single plan would lower costs for beneficiaries who now pay high administrative costs into these private programs.<sup>27</sup> Finally, if beneficiaries forego purchasing Medigap, some of the federal government's costs of increased coverage would be offset through lower use of unnecessary services.<sup>28</sup> At present, the choice is between either very high cost-sharing in traditional Medicare or reliance on supplemental plans that result in nearly first dollar coverage. A better structure for cost-sharing could encourage beneficiaries to seek a middle ground.

Several cautions are very important here. First, both a Rand health insurance experiment in the 1970s and a newer study of cost-sharing indicate that patients tend to forego both unnecessary and necessary services.<sup>29</sup> That is, patients are not very good at determining which services are unnecessary. Further, cost-sharing leads to the greatest declines in use by those with the lowest incomes—reflecting income as well as price effects of cost-sharing.<sup>30</sup> Cost-sharing is not the magic bullet that some proclaim it to be, and it must be used carefully so as not to discourage use of *appropriate* health care services.

An expanded benefits package can provide an additional advantage for traditional Medicare in that further reforms that might coordinate care through disease management or other programs can be effective only if the full range of care is available. High out-of-pocket costs increase the likelihood of noncompliance and the loss of overall savings that such activities might achieve. That is, better outcomes would not offset the extra expense of coordination of care.

Finally, improving Medicare's coverage of healthcare goods and services would ease the burden on states that use Medicaid to fill in the gaps for low

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26. Antos & Bilheimer, *supra* note 17, at 31–32 (stating that restricting supplemental insurance could lead to cost savings).

27. See MOON, *supra* note 4, at 11–12 (discussing the costs of supplemental coverage).

28. CONGRESSIONAL BUDGET OFFICE, MAINTAINING BUDGETARY DISCIPLINE: SPENDING AND REVENUE OPTIONS 172 (1999).

29. See JOSEPH NEWHOUSE ET AL., FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 41–51 (1993) (analyzing the results of a study on the effects that cost-sharing has on beneficiaries' use of medical services); Robyn Tamblyn, *Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons*, 285 JAMA 421, 428 (2001) (same).

30. See NEWHOUSE ET AL., *supra* note 29, at 45–47 (discussing the impact of cost-sharing on low income groups); Tamblyn, *supra* note 29, at 424–28 (analyzing the results of a study on the effects of cost-sharing on low income and elderly people's use of medical services).

income beneficiaries. States, which currently face very high Medicaid costs, spend a great deal on "dual eligibles:" elderly and disabled persons with both Medicare and Medicaid coverage.<sup>31</sup> Acute care benefits for the dual eligibles cost states an estimated \$25.4 billion in 2002.<sup>32</sup> Reducing state burdens—and perhaps even shifting the remaining obligations to the federal government—could achieve two goals: helping states and assuring more equal access for beneficiaries in states that have limited their support for dual eligibles.

Expanding benefits is a separate issue from how the structure of the program needs to evolve over time. But, it is not separate from the issue of the *cost* of new benefits. This problem is quite simply a financing issue, and it would require new revenues, likely from a combination of beneficiary and taxpayer dollars. Congress could ask beneficiaries to pay higher premiums in some cases, but the program is likely to need at least some further subsidies. A concerted effort to expand benefits is necessary to turn Medicare into an efficient and effective program.

### *III. Characteristics of Those Receiving Medicare*

The Medicare population is not a homogenous group. It includes almost all people aged sixty-five and above and more than five million people with disabilities severe enough that they have qualified as permanently and totally disabled for over two years.<sup>33</sup> The aged group also includes healthy individuals in their late sixties who are still actively participating in the labor force. Not only are their health care expenses relatively low, but they may have insurance from their employers, making Medicare secondary and hence subject to even lower liabilities. As people age, their health status and incomes tend to deteriorate. Widowed women in their late eighties often have several chronic conditions that keep their costs of care high and limit their ability to function in the community.<sup>34</sup> But these averages are subject to many exceptions. Older women may also remain healthy and active.

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31. ANDY SCHNEIDER, *THE MEDICARE RESOURCE BOOK* 69–71 (2002) (comparing Medicaid and Medicare).

32. Brian K. Bruen & John Holahan, *Acceleration of Medicaid Spending Reflects Mounting Pressures* 9, at <http://www.kff.org/content/2002/20020611/4056.pdf> (Kaiser Commission on Medicaid and the Uninsured, 2002) (on file with the Washington and Lee Law Review).

33. See MOON, *supra* note 4, at 5–13 (detailing the economic status of the elderly and disabled on Medicare).

34. See MARILYN MOON, *A PLACE AT THE TABLE: WOMEN'S NEEDS AND MEDICARE REFORM* 4 (2003) (comparing elderly female health problems to elderly male health problems).



The same diversity exists in the disabled population. The traditional stereotype in this case is an older worker with a chronic, disabling condition. But, the disabled category also includes much younger persons suffering from a variety of conditions ranging from mental health disorders to paralysis resulting from an automobile accident.<sup>35</sup> If they live alone, the young disabled are very likely to be poor, but if they live with spouses who are in the labor force, the disabled may be relatively well-off. Regardless of age cutoff or other basic demographic characteristics, health care spending is highly skewed with a small number of participants accounting for a substantial amount of total spending.<sup>36</sup> This diversity creates a number of challenges.

Because of the universal nature of Medicare, all of these people are treated essentially the same under the program. That means they vary substantially in terms of what they draw out of the program while paying the same Part B premium. On the positive side, risks are shared broadly across Medicare, providing protection for the most vulnerable. But it also means that if cost-sharing is not well balanced, then the most vulnerable can face high expenses. Further, individuals have differing abilities to pay and obtain supplemental insurance. Figure 2 displays the level of income of Medicare beneficiaries in 2001.<sup>37</sup> In addition, those individuals with strong employer-subsidized insurance will have quite comprehensive coverage, while persons with no such relationships may have to depend upon Medigap (individually purchased supplemental plans), or have no supplemental insurance.<sup>38</sup> Many states do not guarantee the disabled access to Medigap, and some disabled individuals may not be able to purchase supplemental insurance at any price.<sup>39</sup> Those with the lowest incomes have access to Medicaid, but that access varies by state and by the willingness of individuals to participate in a welfare program.<sup>40</sup> Medicaid

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35. See MARILYN MOON, KAISER FAMILY FOUNDATION, *THE FACES OF MEDICARE: MEDICARE AND THE UNDER-65 DISABLED* 1-2 (Fact Sheet No. 1481C, 1999) (describing the characteristics of the disabled on Medicare).

36. Marc L. Berk and Alan C. Monheit, *The Concentration of Health Care Expenditures Revisited*, HEALTH AFF., Mar./Apr. 2001, at 9, 12.

37. This chart was extrapolated from the Current Population Survey of March 2002. Income here is for the "insurance unit." That is, it excludes income from family members other than a spouse. The Current Population Survey of March 2002 is available at <http://www.census.gov/apspd/techdoc/cps/cpsmar02.pdf>.

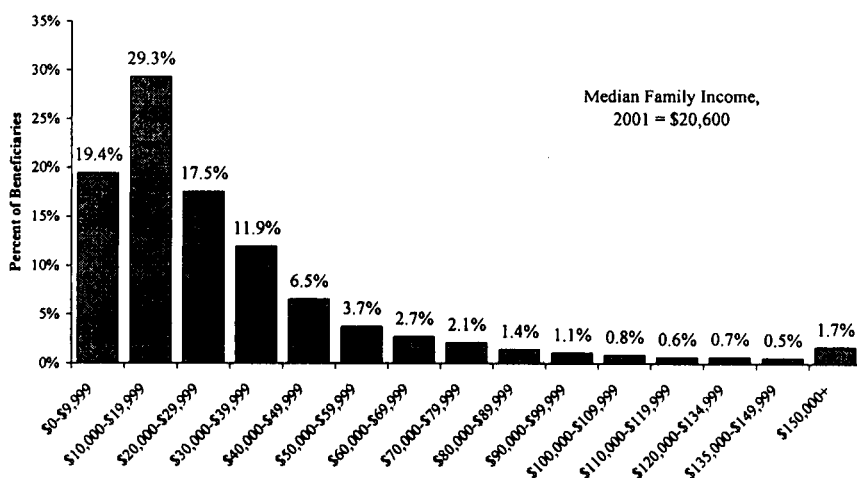
38. See MOON, *FACES OF MEDICARE*, *supra* note 35, at 3-4 (discussing the options of low-income Medicare beneficiaries who do not have employer-sponsored coverage).

39. See *id.* at 1-2 (explaining that the disabled have limited access to Medigap).

40. John Holahan and Mary Beth Pohl, *Leaders and Laggards in State Coverage Expansions*, in *FEDERALISM & HEALTH POLICY* 179, 186-91 (John Holahan et al., eds., 2003).

covers only about 55% of Medicare beneficiaries whose incomes fall below the poverty threshold.<sup>41</sup>

**Figure 2**  
**Family Income of Medicare Beneficiaries, 2001**



Thus, reforms in Medicare affect beneficiaries very differently depending on their financial status and access to viable supplemental insurance. Often, critics of Medicare ask why we should offer coverage to people like "Bill Gates's father" or "Ross Perot." But, chances are that such individuals have paid substantial amounts into the program, while relying on it much less than others. And because they have been in the labor force in recent years, they will have contributed far more than they draw out. Nonetheless, one aspect of the Medicare reform debate might concentrate on making sure that any new or expanded benefits go to those who are most in need. Who are those individuals?

Beneficiaries with either low incomes or substantial health care costs represent the two major groups that most experts would agree are in need. The issues become more controversial when the goal is to establish the cutoffs for such measures. That is, how should Medicaid define what level of income is low? Should Medicare restrict special help to persons with very limited incomes—that is, those with incomes below or just above the official poverty

41. See MOON, *FACES OF MEDICARE*, *supra* note 35, at 1–2 (detailing the number of Medicare beneficiaries that Medicaid serves).

thresholds? The Medicare savings programs assist beneficiaries whose incomes are at 135% of the poverty level or less by paying for their Part B premiums.<sup>42</sup> But, for a single individual, this only protects people with incomes below \$12,123 (in 2003) and the cutoff level for couples is \$16,362.<sup>43</sup> The government would offer no help to a single person with an income of \$15,000, for example, who likely would spend at least a quarter of his or her income on health care.<sup>44</sup>

Because health care is very expensive for Medicare beneficiaries, should the income group cutoff be expanded to include people below 200% of poverty, for example? A range of possible ways to assess this exists, including looking at what other programs provide. The more generous states often offer prescription drug coverage that extends to people with incomes up to 200% or more of the poverty level.<sup>45</sup> Even in the case of children, whose health care tends to be relatively inexpensive, eligibility through Medicaid and/or S-CHIP often reaches 200% of poverty.<sup>46</sup>

At 200% of poverty—or incomes of about \$18,000 and \$24,000 respectively for singles and couples—protections reach high enough up the income scale to allow increases in premiums or cost-sharing for beneficiaries with higher incomes without generating substantial hardships. But 200% of poverty includes nearly half of all Medicare beneficiaries, making the protections for low income persons quite expensive.<sup>47</sup>

If those with high expenses represent another "worthy" group that needs further protection, what should that cutoff be? Should Medicare define the cutoff as a share of income or as an absolute dollar amount? Private insurance often protects workers from cost-sharing once they have spent \$2,000 or \$3,000 out of pocket (or sometimes in the range of \$5,000 for a family).<sup>48</sup> Alternatively, the

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42. See 42 U.S.C. 1396a(a)(10)(E) (2003) (establishing the Qualified Medicare Beneficiaries Program, the Specified Low Income Medicare Beneficiaries Program, and the Qualified Individuals Program, which draw in Medicaid funds to assist Medicare).

43. This would be 135% of the poverty level. See Department of Health and Human Services Notice: Annual Update of the HHS Poverty Guidelines, 68 Fed. Reg. 6456, 6457 (Feb. 7, 2003) (setting the poverty level).

44. MARILYN MOON ET AL., NATIONAL ACADEMY OF SOCIAL INSURANCE, FINANCING MEDICARE'S FUTURE 62 (Sept. 2000), available at [http://www.nasi.org/usr\\_doc/med\\_report\\_financing\\_NO.pdf](http://www.nasi.org/usr_doc/med_report_financing_NO.pdf).

45. Holahan & Pohl, *supra* note 40, at 186–91.

46. *Id.*

47. See CONGRESSIONAL BUDGET OFFICE, ISSUES IN DESIGNING A PRESCRIPTION DRUG BENEFIT FOR MEDICARE 7 (2002) (providing a chart showing the number of beneficiaries at various levels of poverty).

48. See THE KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY 90–95 (2003) (providing data on the

program could set the cutoff to protect people from spending more than a given percentage of income on acute health care.<sup>49</sup>

How does combining these two groups affect the cutoffs? For example, generous low-income protections may allow a catastrophic cutoff to be higher because it would only be relevant for those who have greater resources to meet healthcare needs. If reforms combine these groups, then the share of beneficiaries who would receive help could be quite high. As noted above, a 200% of poverty cutoff for special protections would reach nearly half of all Medicare beneficiaries if they chose to participate. If Medicare offers catastrophic help to the remaining beneficiaries, the program would provide expanded protections to a majority of beneficiaries.<sup>50</sup> If the share getting help becomes very large, then why not simply extend protection to all Medicare eligible persons? Or, why not just reduce the subsidies to the very rich through a Medicare premium, for example? This Article raises various issues in the context of specific potential changes discussed below.

#### *IV. The Impacts of Common Proposals for Improving Benefits*

With the exception of prescription drug proposals, most of the current proposals for expanding the benefit package in Medicare have been relatively modest because of concern about the overall level of spending in the program and its expected growth. Medicare spending totaled \$257 billion in 2002 and has often been one of the fastest growing components of the federal budget.<sup>51</sup> As the Baby Boom generation nears the age of Medicare eligibility and the funding base shrinks over time, policy makers have been very reluctant to expand any part of the program, with the exception of the recent addition of a prescription drug benefit.

#### *V. Adding Prescription Drug Coverage to Medicare*

The 1965 Medicare legislation did not include drug coverage, although policy makers debated its inclusion on several occasions.<sup>52</sup> In the 1970s, when many

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deductibles of private insurance).

49. This alternative complicates the program considerably, however, since this protection would vary by individuals and have to be calculated separately for each enrollee.

50. That is, in combination with the over 40% with low-income protection, about 10–15% would likely receive some type of catastrophic help.

51. See CONGRESSIONAL BUDGET OFFICE, *THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEAR 2003–2004* 84 (providing a chart showing expenditures of government programs).

52. See MYERS, *supra* note 2, at 321–22 (describing failed attempts to add a drug benefit

employers added prescription drugs to their workers' plans, drugs did not constitute a very high proportion of total health care spending.<sup>53</sup> And, when drugs began to be an issue in the late 1970s and early 1980s, large budget deficits and a focus on reducing the size of government dominated the debate on Medicare's future.<sup>54</sup> Some drug protection was part of the catastrophic legislation of 1988, but because Medicare beneficiaries financed it entirely themselves, that legislation was repealed in 1989.<sup>55</sup> During the early part of the 1990s, a prescription drug benefit was part of the Clinton health plan, which failed to pass in Congress. In the late 1990s, Congress placed considerable faith in the private Medicare+Choice option to solve the problem of drug coverage for beneficiaries.<sup>56</sup> Private insurance plans were expected to enroll a larger share of beneficiaries and offer them additional benefits.<sup>57</sup> Now that this expectation has failed, prescription drugs, which have become a major part of health care and a rapidly rising expense for seniors, command considerable attention.

Figure 3 illustrates the distribution of drug spending by Medicare beneficiaries projected for 2005 without accounting for a Medicare drug benefit. The large group of individuals spending in the range of \$2,000 to \$5,000 tend to be people with medications that they take daily for chronic conditions.<sup>58</sup> Drug spending is growing most rapidly in this range. On average, Medicare beneficiaries are expected to spend about \$2,392 each on prescription drugs in 2005.<sup>59</sup> Over a ten year period, spending will total \$1.84 trillion.<sup>60</sup> These figures help to put the substantial commitment of \$400 billion from the Bush administration into perspective. They also help to explain why the

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to Medicare).

53. Marilyn Moon, *Putting the Costs of Prescription Drugs in Perspective for Medicare Beneficiaries*, CARE MANAGEMENT JOURNALS 126, 127 (Spring 2002) (providing a chart showing that prescription drugs accounted for a lower percentage of overall health care spending in the 1970s than in the 1960s or 1990s).

54. See JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 47–48 (2003) (contending that fiscal concerns retarded the growth of Medicare during the 1970s and 1980s).

55. See MOON, *supra* note 4, at 122–27 (detailing the history of the catastrophic health care legislation of 1988).

56. See Marsha Gold, *Medicare+Choice: An Interim Report Card*, HEALTH AFF. July/Aug. 2001, at 120, 121 (describing Congress's motives for enacting Medicare choice).

57. *Id.*

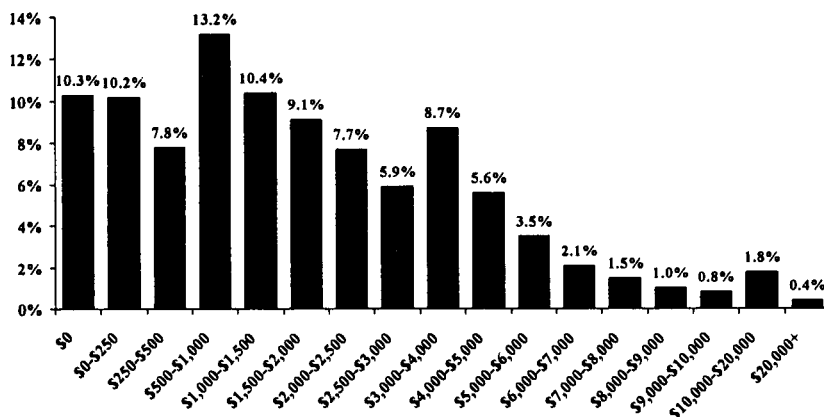
58. Marilyn Moon & Matthew Storeygard, *Stretching Federal Dollars: Policy Tradeoffs in Designing Medicare Drug Benefit* 7 (Commonwealth Fund, 2002), available at [http://www.cmwf.org/programs/medfutur/moon\\_feddollars\\_pb\\_544.pdf](http://www.cmwf.org/programs/medfutur/moon_feddollars_pb_544.pdf) (on file with the Washington and Lee Law Review).

59. Urban Institute analysis based on 1999 MCBS, projected to 2005 (on file with the Washington and Lee Law Review).

60. *Id.* at 3.

structure of a drug benefit quickly becomes very complicated when the funds are insufficient.<sup>61</sup>

**Figure 3**  
**Distribution of Beneficiaries**  
**by Level of Prescription Drug Spending, 2005**



Source: Urban Institute analysis of the 1999 MCBS, projected to 2005

Note: Excludes facility beneficiaries

Expanding Medicare to cover prescription drugs will be quite expensive and represents a shift in the two-decade trend of promoting policies to hold down costs in the program. Drugs will constitute an exception to the reluctance of many policy makers to expand Medicare. The exception took form because a drug benefit was promised by almost all national politicians in the campaigns of both 2000 and 2002. With full control of the Presidency and the Congress, Republicans feel a need to deliver on this promise; it will be difficult for either Democrats or Republicans to rely on finger-pointing as both parties have done thus far.

The structure of a drug benefit varies depending upon a number of key components. These components include: stop-loss levels, co-insurance (or copayments),<sup>62</sup> deductibles, caps on benefits, eligibility requirements based on

61. See Moon & Storeygard, *supra* note 58, at 4–7 (describing the inherent difficulties in implementing a prescription drug benefit with insufficient resources: either benefits must be too low or premiums too high for a substantial portion of potential beneficiaries).

62. Co-insurance is usually expressed as a percentage of the costs of the drug, while a copayment is a fixed dollar amount. Private drug plans use both approaches, sometimes in combination. Co-insurance makes consumers aware of the costs of each prescription and is thus

income, and premiums. These various pieces can be used in many combinations to achieve various goals.<sup>63</sup>

Stop-loss limits provide protection in the event of catastrophic circumstances. Table 1 indicates the proportion of beneficiaries who would be helped by a drug stop-loss of various levels and the share of total spending that would be paid by the government (assuming no increase in use). A low stop-loss would help a larger share of people but at a very high cost. Programs usually provide a stop-loss in combination with protections that begin at lower levels of spending on drugs. If the program provides a stop-loss as a stand-alone benefit, then policy makers would likely need to set a lower limit to include a substantial minority of the population. Otherwise, voters may discount the value of such a benefit.

**Table 1: Total Government Expenditures Under Different Stop-Losses, 2005**

Stop-Loss of	Share of Total Drug Spending	Share of Medicare Population Affected
\$8,000	8.4%	3.9%
\$7,000	10.4%	5.4%
\$6,000	13.2%	7.4%
\$5,000	17.2%	10.9%
\$4,000	23.2%	16.5%
\$3,000	32.4%	25.2%
\$2,500	38.7%	31.1%
\$2,000	46.4%	38.8%
\$1,500	56.0%	47.9%
\$1,000	67.9%	58.3%

A second key component of any benefit package is the co-insurance charged once a benefit begins. For example, a 20% to 25% co-insurance would

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avored by those who worry that people will demand more expensive drugs.

63. See Moon & Storeygard, *supra* note 58, at 2-3 (listing and discussing the various goals that different combinations of the previously mentioned components can further: staying within federal budget constraints; making partial benefits available to all; protecting those with high expenditures; encouraging large scale, voluntary participation; and protecting beneficiaries with low incomes).

be in line with what younger families currently face, but this arrangement would become very costly to insurers. Many proposals carry a 50% co-insurance rate for part of the benefit to lower the costs of coverage, leaving a substantial burden on the beneficiaries.

A third component is the deductible. Routine expenses below a given amount (such as \$250) would not qualify for any protection. Once the deductible is met, the co-insurance rate would go into effect. This arrangement could help hold down costs, but may discourage participation by healthy beneficiaries.

A fourth component is a cap on benefits. This proposal is the opposite of stop-loss protection; that is, once an enrollee hits a certain level of expenditures, benefits end. Some proposals contained both a cap and stop-loss protection, effectively creating a range in which there is no coverage. Experts have referred to this range as the "donut hole."

Most options also require that the beneficiary pay for part of the costs of insurance through a premium.<sup>64</sup> For example, if a 50% premium is assessed and the individual faces 50% co-insurance, the enrollee receives a government subsidy of 25%. But, if the premium is high, participation will likely be lower and risk selection will occur, causing costs to rise rapidly over time.<sup>65</sup> Even with an attractive benefit package, high premiums may result in low participation.

Figure 4 compares the impact on beneficiaries with various levels of drug spending based on two proposals.<sup>66</sup> The first level was enacted into law in December of 2003.<sup>67</sup> It would begin with a deductible of \$250, and cover 75% of prescription drug costs above the deductible until total spending reached

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64. See KAISER FAMILY FOUND., HEALTH POLICY ALTERNATIVES, PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES: A SIDE-BY-SIDE COMPARISON OF SELECTED PROPOSALS 11 (2002) (outlining the premiums payable to beneficiaries under five proposed congressional plans for a prescription drug benefit).

65. See CONGRESSIONAL BUDGET OFFICE, *supra* note 47, at 20 (describing the risk of adverse selection into a program, in which healthy beneficiaries opt out of coverage to avoid high premiums, pushing premiums even higher and benefits lower).

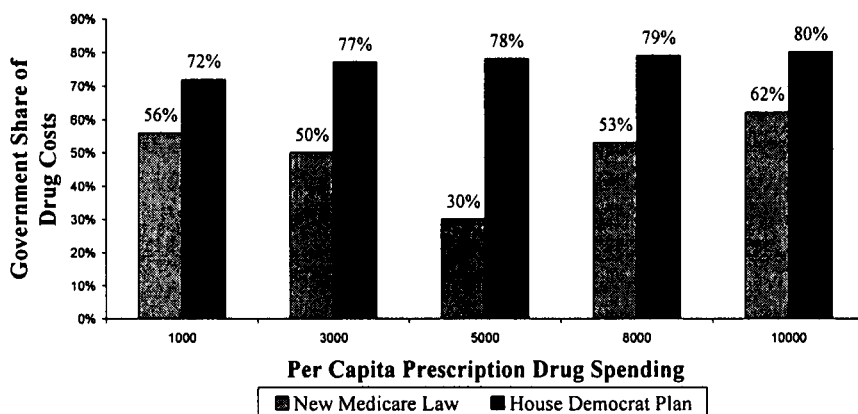
66. Figure 4, as well as the hypothetical numbers cited in this paragraph, are derived from the House Democratic Plans and the legislation that passed in November 2003. See *A Side by Side Comparison of the Prescription Drug Coverage Provisions of S. 1 and H.R. 1* 6–7 (Kaiser Family Foundation, 2003), available at <http://www.kff.org/content/2003/6103/6103.pdf> (providing descriptions and analysis of the new prescription drug benefit) (on file with the Washington and Lee Law Review); see also *Resources on the Medicare Prescription Drug Benefit*, at <http://www.kff.org/medicare/rxdrugdebate.cfm> (Kaiser Family Foundation, 2003) (describing the two prescription drug plans).

67. Robert Pear, *Bush May Link Drug Benefit in Medicare to Private Plans*, N.Y. TIMES, Jan. 24, 2003 at A1.



\$2,250. Then, no coverage would be offered until individuals spend \$3,600 out of pocket (which would occur after total spending reaches \$5,100), after which 95% of the costs above that amount would be paid by government.

**Figure 4**  
**Government Contribution, As a Share of Total Prescription**  
**Drug Spending, Under the House Democrat Plan**  
**and Final Medicare Legislation**



A proposal from the Democratic leadership, in contrast, is much simpler—and much more expensive. It would cover 80% of the costs of prescription drugs after a \$100 deductible up to a cutoff of \$2,000, after which the government would pay all the remaining costs.<sup>68</sup> As Figure 4 indicates, the new Medicare law will cover only limited amounts of the examples shown. Because of the gap in coverage above \$2,250, even someone with \$10,000 of expenses would only have about 62% of their costs paid by the government, and at \$5,000, the new law will only cover 30% of drug costs. The House Democratic plan, on the other hand, rises to 80% after the impact of the deductible wears off.<sup>69</sup> The premiums to be paid by individuals signing up for these plans are not demonstrated in Figure 4, but are also important. The Democratic option, for example, assumes a \$25 monthly premium to be paid by those participating, while

68. Democratic Staff of Energy and Commerce and Ways and Means Committees, Medicare Rx Drug Benefit and Discount Act, memo, Mar. 2, 2003.

69. *Id.*

the Bush administration's plan was not specific.<sup>70</sup> Presumably, it will be in the range of \$35 per month.<sup>71</sup>

As mentioned above, substantial differences in costs of the program would be driven by both coverage differences and other plan details. Even without these differences, the Democratic plan would likely cost more than twice as much as the recently enacted law.<sup>72</sup>

Finally, the issue of additional protections for those with low incomes is very important. If the overall benefit is comprehensive, the costs of low-income protection may be relatively minimal because fewer costs will need to be subsidized. In addition, the income cutoff level for eligibility will be lower if the overall benefit is generous. Low-income protections represent a vital part of any proposal; careful thought is needed about eligibility requirements, access levels, and limits on generosity. Coordination with Medicaid and other drug programs would also need to be addressed. As mentioned above, the number of beneficiaries eligible for protection rises rapidly as the income cutoff rises. If there is also an asset test, however, the proportion eligible would likely fall substantially because asset limits tend to be quite stringent.<sup>73</sup>

A large number of Medicare beneficiaries have modest incomes, thus the cost of providing drug benefits to this subgroup of low-income persons will be quite high, particularly if that protection is comprehensive. For example, in an earlier study, the author concluded that a low income benefit could cost up to \$300 billion while aiding just 15% of the Medicare population.<sup>74</sup> Furthermore, that study assumed that only 54% of those eligible would likely participate, and a large number of other beneficiaries with modest incomes and no access to reliable coverage would be ineligible.

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70. *Id.*

71. See KAISER FAMILY FOUND., *supra* note 64, at 11 (noting that congressional staff sources estimate the drug benefit in H.R. 4954 would include a \$35 per month premium).

72. See *id.* at 60 (reporting that the CBO estimates that from 2005–2012 a less generous Graham plan would cost \$594 billion, while the Republican plan passed by the House would cost about \$400 billion).

73. See MOON, *supra* note 34 (explaining that even moderate asset tests could have the effect of excluding a substantial portion of potential beneficiaries).

74. MARILYN MOON & MATTHEW STOREYGARD, KAISER FAMILY FOUND., TARGETING MEDICARE DRUG BENEFITS: COSTS AND ISSUES 2 (2001) (suggesting that only 6.2 million people would be helped by such a plan).

## VI. Changing the Cost-Sharing Structure of the Current Program

Much of the criticism directed at Medicare's cost-sharing in recent years has focused on the two deductibles in Medicare. Medicare's two deductibles do not make the program unusual; its uniqueness stems from the fact that the Part A deductible is so much larger than that for Part B. Elsewhere, insurers often recognize that physician services tend to be more subject to discretion than hospital care, and hence, establish a higher deductible for physician services.<sup>75</sup> In Medicare just the opposite occurs, as noted above. Proposals often address these two deductibles simultaneously because raising Part B deductibles can help pay for lowering Part A deductibles. Alternatively, the two deductibles could be combined—a particularly popular approach at the present time.<sup>76</sup>

But, if individuals face a combined deductible aimed at keeping the overall contribution at about the same level as that raised by the two current deductibles, the redistributive impacts would be substantial. Medicare beneficiaries who have at least one hospitalization in the year would benefit compared to those who use only Part B services.<sup>77</sup> Compare this change to an increase in the Part B deductible only, which would achieve approximately the same amount of savings to the federal government (an average \$55 increase in cost-sharing per beneficiary). As Table 2 indicates, the combined deductible would decrease cost-sharing for a substantial number of beneficiaries while increasing it just 56%. The reduction in cost-sharing for beneficiaries whose Medicare-related expenses put them in the top 20% of Medicare cost-sharing liability would be over \$200 as compared to an average *increase* of \$80 from the Part B deductible change. Making separate changes, in which the Part A deductible is reduced and the Part B deductible is increased, also yields different distributional impacts.

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75. MOON, *supra* note 4 (pointing out that although Medicare's drafters originally set Part A deductibles lower than Part B deductibles, Part A deductibles have since grown much larger than Part B deductibles).

76. A number of other adjustments would be needed, since Parts A and B are now separate programs.

77. This is because the inpatient hospital deductible is so high, currently \$840. HHS Notice, *supra* note 23, at 64,642.

**Table 2: Impacts of Possible Cost-Sharing Changes**

Options	Average Change in Cost-Sharing	Change in Cost-Sharing for Top Quintile of Liability	% with Cost-Sharing Decrease	% with Cost-Sharing Increase
A/B Combined Deductible of \$400	+ \$55	- \$229	16%	56%
B Deductible of \$200	+ \$55	+ \$80	0%	71%
A/B Combined Deductible of \$500 & Stop-Loss of \$3000	- \$57	- \$654	18%	54%
B Deductible of \$300 & Stop-Loss of \$3000	- \$68	- \$436	6%	66%
B Deductible of \$200; A Deductible of \$400; 0 inpatient co-insurance	- \$61	- \$437	17%	55%
Stop-Loss of \$7,500	- \$49	- \$115	1%	0%

An important complicating factor is the existence of supplemental insurance because it can effectively blunt the redistributive impact of both changes. About 10% of Medicare beneficiaries have no supplemental insurance.<sup>78</sup> Lowering the cost of the hospital deductible would benefit both those hospitalized and those not hospitalized who purchase insurance because the actuarial value of the insurance, and hence the premiums, should fall. Even if the changes on balance are budget neutral, premium changes may still result.

For example, in recent years, most Medigap premiums are age-rated, meaning that older persons pay much more on average than those aged 65

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78. See Laschober et al., *supra* note 16 (reporting that nine out of ten beneficiaries rely on supplemental insurance to fill gaps).

to 69. Older persons can pay as much as 33% more.<sup>79</sup> Thus, to the extent that changes in cost-sharing are made to ease the burdens on the very old—who disproportionately use services such as hospitals and post-acute care—the types of changes discussed here would help to reduce burdens on older beneficiaries who rely on Medigap. Together, the group of individuals who rely on Medigap and Medicare only represent about one-third of all beneficiaries.<sup>80</sup> But, this group is disproportionately concentrated among the old and in the income group between 150% and 250% of poverty.<sup>81</sup>

Another unusual aspect of Medicare is its linkage of hospital co-insurance to hospital stays longer than sixty days.<sup>82</sup> This provision sets cost-sharing highest for those who are sickest. Changes to simplify and reduce this cost-sharing would not be very expensive.<sup>83</sup> Moreover, today there are other constraints on use of hospital care, such as pre-admission screening, that serve to limit inappropriate use. In the case of current co-insurance requirements for very long stays, hospitals themselves now have strong incentives to release their patients as early as possible because of incentives established by the Prospective Payment System (PPS).<sup>84</sup> The same problem arises with skilled nursing facility co-insurance, which effectively limits the length of stay in these facilities for many beneficiaries.<sup>85</sup> Thus, restructuring the deductibles (and potentially eliminating hospital co-insurance) could improve the Medicare program by shifting cost-sharing to those areas where the incentives might be more effective.

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79. Letter from Laura Dimmit, General Accounting Office, to Rep. John Dingell (Mar. 1, 2000), GAO/HEHS-00-70R.

80. See *Medicare Cost-Sharing: Implications for Beneficiaries, Testimony Before the House Ways and Means Subcommittee on Health*, 18th Cong., 2003 WL 2008102 at \*18 (May 1, 2003) (statements of Patricia Neuman, Vice President and Director of the Medicare Policy Project, Kaiser Policy Project, and the Henry J. Kaiser Family Foundation) (discussing Medicare's cost-sharing system).

81. Laschober et al., *supra* note 16.

82. 42 U.S.C. § 1395(e)(a)(3) (2003).

83. See MICHAEL GLUCK & MARILYN MOON, NATIONAL ACADEMY OF SOCIAL INSURANCE, *FINANCING MEDICARE'S FUTURE* 76–78 (2000) (presenting four options for reworking Medicare's cost-sharing requirements, one increasing costs, one not changing costs, and two reducing costs).

84. See MOON *supra* note 4, at 59–60 (reporting that two years after the implementation of the PPS program, hospitals reduced the average stay for Medicare patients from 9.7 days to 8.7 days and suggesting that the shorter stays resulted from the incentives in the PPS program).

85. See *id.* at 226 ("SNF co-insurance largely limits the program to a 20-day benefit rather than a 100-day benefit because of high co-insurance costs.").

### VII. Stop-Loss Protection

One of the areas of greatest concern to health policy professionals in assessing the quality of health insurance is whether it offers good stop-loss protection—that is, the guarantee that above a certain threshold, the individual should not have to continue to pay out of pocket for covered services. This area is one of Medicare's greatest weaknesses. The program provides no limit on the amount of cost-sharing that beneficiaries could be responsible for paying.<sup>86</sup>

Most private plans offer stop-loss protection so that once patients have spent a certain amount out of pocket, cost-sharing payments cease.<sup>87</sup> Medicare has no such provision. Beneficiaries with complicated illnesses (and no supplemental protection) may incur tens of thousands of dollars of debt towards the costs of Medicare covered services. This scenario is particularly likely under Part B of the program, where 20% co-insurance can grow quite large for those with extensive medical bills.<sup>88</sup> Part B cost-sharing constitutes about two-thirds of all Medicare cost-sharing liabilities.<sup>89</sup>

Many beneficiaries do not view the coverage problem this way. Traditionally, Medicare enrollees have been more concerned about choosing supplemental policies on the basis of first-dollar rather than last-dollar coverage. Further, beneficiaries objected to the MCCA because they did not view the benefits as being as comprehensive as the supplemental benefits they already had.<sup>90</sup> Nonetheless, adding good stop-loss protection to Medicare would be an important improvement in the program's fundamental insurance function. Finally, many beneficiaries already implicitly have such protection once their supplemental insurance or Medicaid is taken into account.

The higher the stop-loss cutoff, the less expensive the protection. But, the disparity in incomes across beneficiaries always creates a dilemma. For example, a \$5,000 cutoff is still low enough to be expensive to provide but high

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86. *Id.*

87. See THE KAISER FAMILY FOUND. & THE HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2002 ANNUAL SURVEY 110 (2002), available at <http://www.kff.org/insurance/325/.pdf> (reporting in exhibit 8.5 the percentages of private firms that offer stop-loss protection at various levels) (on file with the Washington and Lee Law Review).

88. See 42 U.S.C. § 1395(f)(a) (2003) (ordering a 20% copayment).

89. See HEALTH CARE FINANCING REVIEW, MEDICARE AND MEDICAID STATISTICAL SUPPLEMENT, at <http://www.cms.hhs.gov/Review/Supp/> (2002) (reporting in Figure 17 that in 1998, Part B hospital insurance cost-sharing liabilities totaled \$8,744,000,000, while Part B Supplemental Medical Insurance cost-sharing liabilities totaled \$18,214,000,000) (last visited Nov. 4, 2003) (on file with the Washington and Lee Law Review).

90. Thomas Rice et al., *The Medicare Catastrophic Coverage Act: A Post Mortem*, HEALTH AFF., Fall 1990, at 75, 80–86.

enough to constitute a substantial burden for those with modest incomes. One possible solution is to add the stop-loss in combination with other changes such as the deductible increases described above, thus holding down costs. Again, as Table 2 illustrates, the average impacts of various alternatives may be similar, but the consequences on very high users will vary substantially. As illustrated here, a stand-alone stop-loss of \$7,500 would provide much lower benefits to high users, although it would not raise anyone's cost-sharing. Notably, a combined A/B deductible with a stop-loss offers better protection at the high end than do the other options. Essentially, such an approach offers double benefits for persons who are hospitalized, reducing initial cost-sharing and then providing additional protection from high Part B co-insurance.

A second way to provide meaningful stop-loss protection for those with low incomes would be to create a different level of aid for those with limited resources. Medicaid's expansion over the years has provided comprehensive protection for low-income beneficiaries with incomes up to the poverty guidelines, at least on paper. About 10% to 12% of Medicare enrollees now have such protection.<sup>91</sup> The share of people receiving stop-loss support could be raised considerably, for example, by paying the Part B premiums of those up to 150% or 200% of poverty and establishing a stop-loss in the range of \$2,000. Above that level, the stop-loss could be set considerably higher. Participation issues remain a problem, however, when dealing with a "welfare" approach.

### *VIII. Making Choices*

This Article has described a broad range of possible changes, each of which is likely to meet some of the goals for Medicare's future. But, in almost all cases, tradeoffs with less-desirable outcomes are also likely to occur. Thus, policy makers need to establish priorities to rank the various goals and then seek changes that will best meet those priorities.

Because Medicare is a program designed to aid the elderly and disabled, positive impacts on its beneficiaries should be near the top of the list of any goals. The program should strive to protect the sicker and lower income beneficiaries. Further, a beneficiary focus also promotes the goals of social

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91. JOCELY GUYER, KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE PROPOSED MEDICARE PRESCRIPTION DRUG BENEFIT: A DETAILED REVIEW OF IMPLICATIONS FOR DUAL ELIGIBLE AND OTHER LOW-INCOME MEDICARE BENEFICIARIES 4 (Sept. 2003), *available at* <http://www.kff.org/content/2003/4135/4135.pdf> (on file with the Washington and Lee Law Review).

insurance—that is, spreading risks broadly and treating people alike when possible.

On the other hand, a number of beneficiaries are likely to oppose broad expansion of the Medicare program. For example, those who have good retiree coverage (representing about a third of beneficiaries) are now well covered and likely would gain little from a mandatory benefit expansion coupled with higher Part B premiums. Employers could certainly respond by raising benefits elsewhere, but they might also simply cut back and not compensate their retirees for duplicative protection. This concern has always been an issue in discussions of benefit expansions and is one of the likely reasons why the 1988 catastrophic legislation failed.

Program simplification and improved efficiency may also aid beneficiaries. Changes that provide a better value for the dollar are in the interest of both beneficiaries and the federal government (taxpayers). These changes likely translate into more effective cost-sharing by better targeting and by discouraging purchase of supplemental insurance. But, there is a fine line to tread in order to preclude the negative effects of shifting costs to beneficiaries.

Operating as a constraint on change are the goals of some policy makers to limit any increase in federal costs and to keep the size of government small. Rebalancing cost-sharing is likely to be an appropriate step for many with these goals, but usually in a cost-neutral way. And some, who wish to see the size of government's role in Medicare shrink substantially, may be opposed to any improvements that will help people stay in traditional Medicare.

### *IX. A Basic Possible Set of Changes for Medicare*

What can be done within these types of constraints? The 2003 debate allocated \$400 billion over ten years largely to provide a prescription drug benefit. But, if that alone is done, an important opportunity to improve the basic cost-sharing in Medicare will likely be lost for some time. In fact, under the plan passed by the House in 2003, cost-sharing elsewhere in Medicare would be *increased*.<sup>92</sup> Even if the program keeps a drug benefit separate from other cost-sharing mechanisms, a *combination* of protections for those with high costs in the current Medicare-covered service area and a drug benefit would allow many to forego purchasing Medigap insurance. In that way, individuals could save the Medigap dollars to pay somewhat higher Part B premiums and put aside resources to pay for taking on more direct cost-sharing.

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92. See *A Side by Side Comparison*, *supra* note 66 (describing the House-passed plan).



Key tradeoffs include whether to emphasize overall stop-loss or treat Parts A and B separately (for example with Part B stop-loss and Part A limits on the deductible and hospital co-insurance). Policy makers could offset the costs of this enhanced protection by increasing the Part B deductible, creating a combined A/B deductible, or raising the Part B premium. A premium spreads the costs as broadly as possible but does not increase incentives for more appropriate use. Thus, it may be less preferable compared to a combined A/B deductible. Legitimate reluctance remains to increasing either premiums or deductibles by so much as to make care unaffordable to patients, particularly those with modest incomes. Policy makers should use such increases only if effective low income protections are in place and if this change would result in at least some beneficiaries believing they could forego purchasing Medigap.<sup>93</sup>

#### *X. A Two-Tier Approach to Medicare*

One way around the issue of balancing the affordability of expanded benefits and a desire to have benefit levels be sufficient to eliminate the need for Medigap is to offer two options under Medicare—a high coverage option and a basic coverage option. The rationale behind this approach is that some individuals would prefer to stay with private supplemental insurance, particularly those covered by employer-subsidized plans who might see little to gain from paying a much higher Part B premium. But, even the basic plan should be improved in ways that would allow at least some beneficiaries to forego purchasing Medigap. Providing stop-loss and some drug protection would help reduce some of the risk problems that would likely occur from having two tiers.

One way to do this would be to retain Part A coverage with some improvements for all beneficiaries. Policy makers could substantially reduce the Part A deductible and eliminate the hospital co-insurance, for example. Under the basic option, a nearly budget neutral change would raise the Part B deductible and add a Part B stop-loss. This approach would modestly improve Medicare's coverage, while keeping the premium at a relatively low level. Policy makers could also add a stop-loss drug benefit, requiring only a modest Part B premium increase.

Those beneficiaries desiring an expanded benefit package could alternatively enroll in a broader Part B benefit package designed to offer more comprehensive coverage and replace the need to purchase Medigap. This

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93. Another important issue is the impact on employer-subsidized retiree insurance.

package could reduce the cost-sharing burden of skilled nursing facilities by buying down the amount charged under Part A, raising the deductible, lowering cost-sharing on Part B, and providing a lower Part B stop-loss. Policy makers would likely need to take special care to prevent risk selection from getting out of hand between the two options. Because the government would be responsible for the risk under both Part B options, it could design premium changes that attempt to keep the playing field level.

The difference between this approach and what the administration and others have been supporting is that basic coverage would still remain under the aegis of the traditional Medicare structure, and for the expanded option, individuals could choose either Medicare or a private plan.

To protect low income persons, the federal government could be responsible for buying them into the higher option—that is, eliminating their premium contribution. This approach would relieve Medicaid of many of the dual-eligible burdens both by taking over the buy-in function for the premium and by reducing the gaps that Medicaid now fills for the basic benefit package. Medicaid would still have to fill in some cost-sharing, but at a much lower level. If the protections are sufficiently generous to extend up the income scale to at least 200% of the poverty level, for example, then the premiums could be kept relatively high for the second option.

### *XI. Conclusions*

Improving the Medicare benefit package should help to put the program back on a firm basis. Improvement would change the perception that the benefit package is outmoded. By covering all the basic services needed for acute care, delivery of care would be less likely to be distorted regardless of whether that delivery takes place in traditional Medicare or a private managed care plan. It could reduce reliance on a creaky system of supplementation that payors, beneficiaries, former employers and state governments are finding increasingly difficult to sustain. The government cannot avoid devoting more resources to the program, and the costs should be split between beneficiaries and taxpayers based on an informed debate regarding who is most able to pay.

