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# Medicare Matters: Building on a Record of Accomplishments

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*Medicare's successes over the past 35 years include doubling the number of persons age 65 or over with health insurance, increasing access to mainstream health care services, and substantially reducing the financial burdens faced by older Americans. Medicare reform remains high on the list of priorities of many policymakers because of rapid past and expected future growth in Medicare. If the original goals of the program—including providing mainstream care, pooling of risks, and offering help to those most in need—are to be protected, however, a go-slow approach for greater reliance on the private sector is in order.*

## INTRODUCTION

Thirty-five years ago, the Medicare program was passed as part of the Great Society legislation of the Lyndon Johnson years, although it had its antecedents in earlier national health insurance proposals. Since 1966, when the program first enrolled beneficiaries, it has succeeded in covering almost all persons age 65 or over, and later, a substantial number of persons with disabilities. Moreover, Medicare provides its beneficiaries with access to most doctors, hospitals, and other providers of health care services. It remains one of the most popular public programs and gets higher marks from its beneficiaries than do most private health insurance companies serving the younger population. In 2000,

Medicare served 39 million beneficiaries—more than a doubling of the number covered in 1966.

At the same time, since the 1980s, there have been recurring efforts to slow the growth in Medicare spending, and since the 1990s, there has been a call for even more dramatic measures to “save” Medicare. Spending on the program of \$213 billion in 1999 represents a large commitment of resources. But calls for major reform also have critics who maintain that such changes could undermine the program’s basic strengths. The stakes in this debate will intensify as the number of persons eligible for Medicare swells with the aging of the baby-boom generation.

Before examining issues facing Medicare, it is important to put the debate in context with a look both at past performance and at some of the original goals of the Medicare program. Will Medicare’s future keep faith with its past?

## MEDICARE’S ACCOMPLISHMENTS

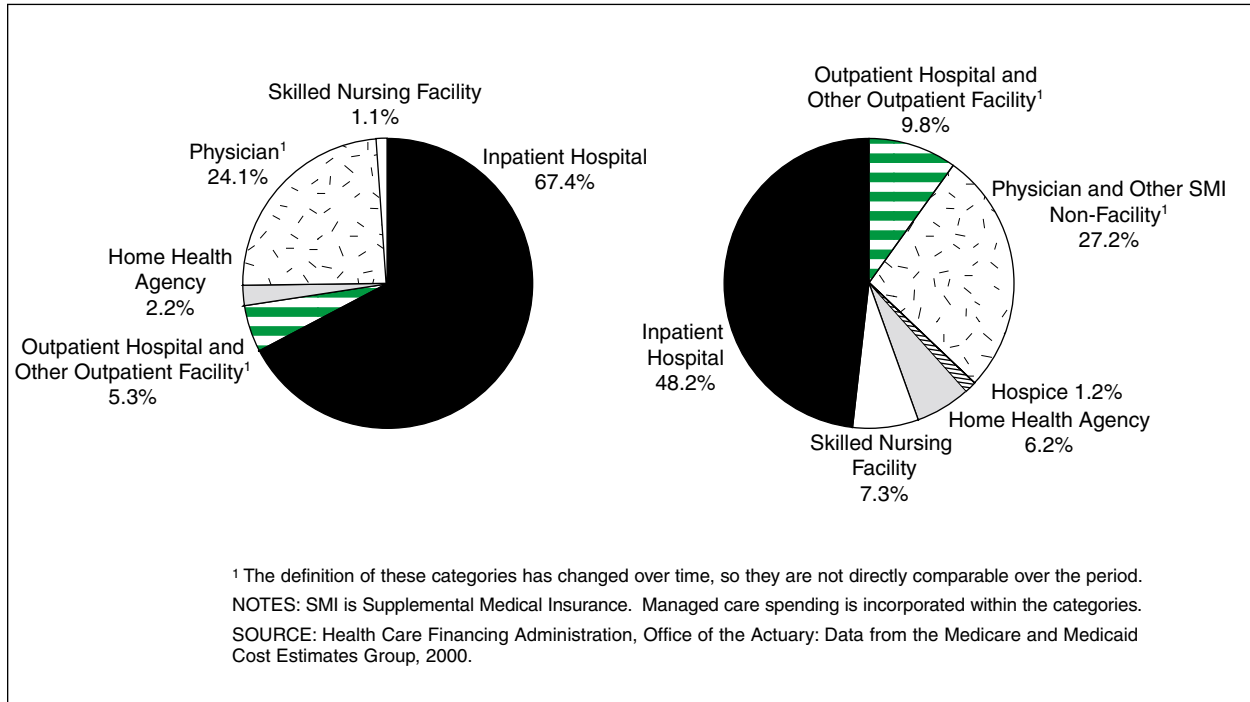
When Medicare began in 1966, it almost immediately doubled the share of persons age 65 or over covered by insurance. Before Medicare, only about one-half of persons in this age group had insurance (Andersen, Lion, and Anderson, 1976). By 1970, 97 percent of older Americans were enrolled, and that proportion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

Two effects followed immediately: Use of services by the population grew, and financial burdens on older Americans and their families declined. Thus, access increased, particularly for those who previously

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The author is with The Urban Institute. The views expressed in this article are those of the author and do not necessarily reflect the views of The Urban Institute or the Health Care Financing Administration (HCFA).

**Figure 1**  
**Where the Medicare Dollar Went: 1980 and 1998**



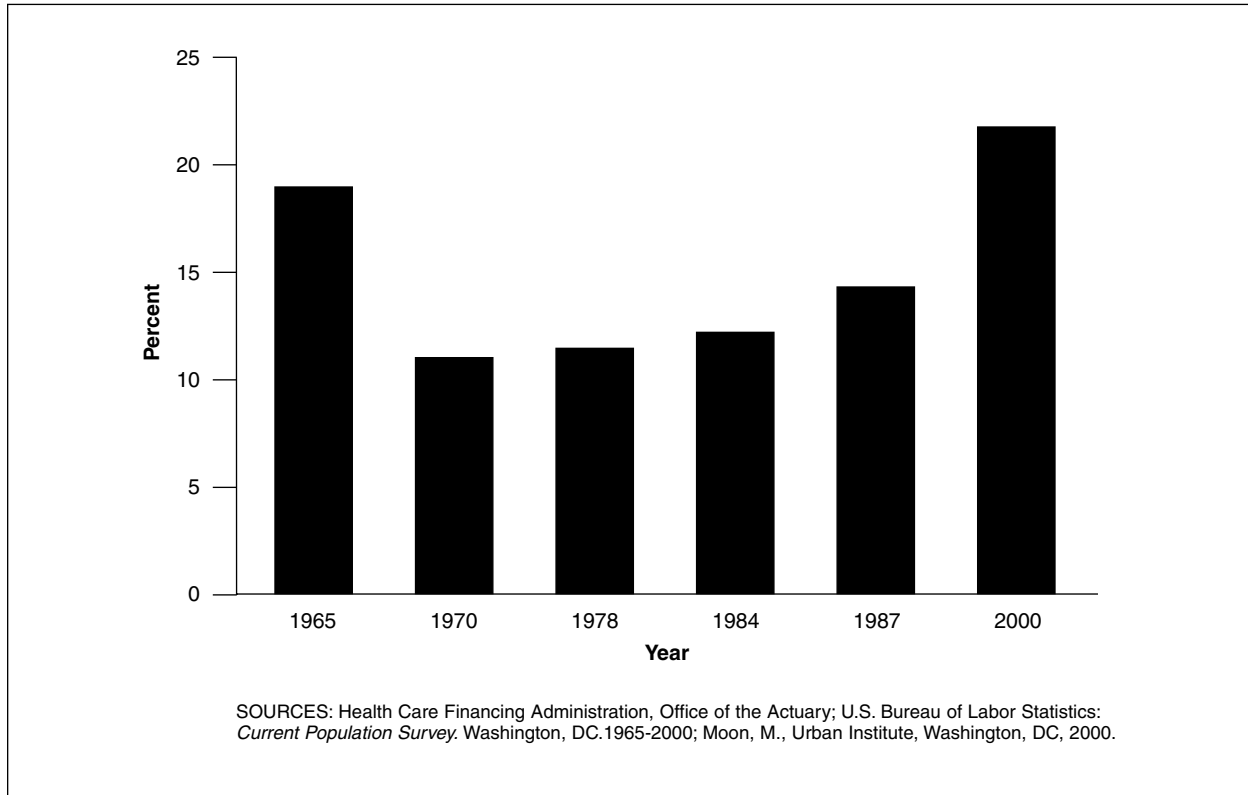
lacked the resources to obtain services. Although Medicare's benefit package has changed little since 1965, in those areas where services are covered, the program has kept up with the times (Figure 1). Many surgeries are now performed on an outpatient basis, for example. Today, even the oldest old have access to mainstream medical care. New technology is available to beneficiaries, and in some cases, the dissemination of new procedures occurs at a faster pace for the old than for the young (Moon, 1999). Perhaps even more important, Medicare played a crucial role in speeding the desegregation of hospitals and other medical facilities, ensuring not only that minority seniors would receive care but that minority persons of all ages would have access to health care services. It is easy to forget that in 1965, for example, many black people could not go to the best hospitals, particularly in the South (Height, 1996; Stevens, 1996).

Financial burdens for seniors also fell nearly in half as a result of Medicare's introduction. Over time, the share of income that seniors spend on health care has crept back up, but the burdens would be much greater if Medicare were not there. In 1965, the typical elderly person spent about 19 percent of his or her income on health care. That share fell to about 11 percent in 1968. Today it is more than 20 percent (Figure 2). Medicare's contribution to the costs of health care for seniors totals more than \$5,300, nearly 40 percent of the median income of persons age 65 or over. So, without Medicare, most of those now covered would pay more for their care, and many people would likely have to cut back on the amount of care they receive.

Even in the area of the costs of care, Medicare can point to substantial accomplishments. It was a leader in cost-containment activities in the 1980s, improving upon payment to hospitals and doctors by shifting

Figure 2

Acute Health Care Spending by Elderly as a Share of Income: Selected Years, 1965-2000



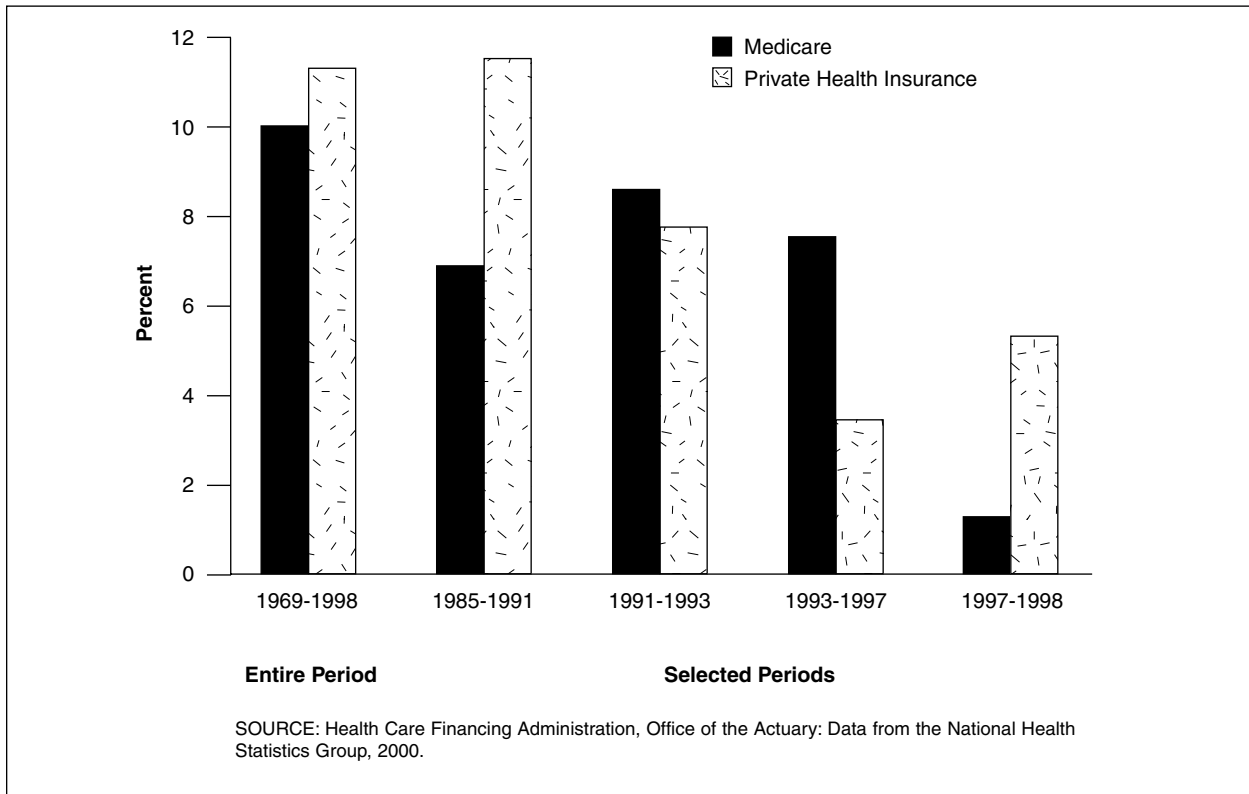
from a cost-based system to one in which payments are known and, in the case of hospitals, do not encourage excess use of services. Both of these systems have since been adopted by a number of other insurers. Further, these and other changes helped moderate the growth of Medicare spending such that, on a per capita basis, Medicare payments have grown more slowly than private insurance costs in most years (Figure 3). Moreover, on a cumulative basis, Medicare has performed better than private insurance from 1970 to 1997 despite increased efforts by employers to move those they cover to managed care in the 1990s (Moon, 1999).

Medicare has also changed over time to allow beneficiaries to choose to be served by private plans instead of remaining in the traditional fee-for-service part of the program. In 1997, this option was modified to allow plans other than health maintenance organizations (HMOs) to participate and to

reform the payment system that, on average, costs Medicare more for each enrollee than if they remained in the traditional program (Riley, Ingber, and Tudor, 1997). This new Medicare+Choice benefit has been one of the least successful changes in Medicare. The limits imposed on payments by 1997 legislation have been strongly criticized by the private sector, creating an impasse in the program that will be difficult to overcome. Plans will likely continue to withdraw from participation, and there will be efforts to increase payments to plans, even if this means a less efficient Medicare program.

Finally, improvements in life expectancy since 1965 have occurred at a faster pace for persons age 65 or over than for the population as a whole. In 1960, females faced a life expectancy at age 65 of 15.8 years; by 1998, that figure was up to 19.2 years. For males, the increase in life expectancy over the same period was from 12.8 to 16.0 years (National

**Figure 3**  
**Average Growth in per Enrollee Medicare and Private Health Insurance Spending:**  
**Selected Periods, 1969-1998**



Center for Health Statistics, 2000). Some of this improvement is undoubtedly a byproduct of Medicare and Medicaid.

### **BASIC ISSUES FACING FUTURE REFORMS**

Sometimes lost in the enthusiasm to reform Medicare is a careful assessment of whether the original principles and goals for the program can and should be retained. Each of these goals raises questions that need to be revisited in any debate about Medicare's future.

#### **Mainstream Care**

During the debate over Medicare's passage, a clear goal was to assure that beneficiaries had access to mainstream care. With criticism and concern expressed by the

providers of care, there was reason to worry that Medicare would be considered a second-class program. Efforts to address this concern occurred on several levels: making the program operate like other good private insurance policies of the time and structuring Medicare so as to encourage most providers of health care to participate in it. The legislation thus contained assurances about levels of payment and non-interference in the practice of medicine (Myers, 1970).

Today, this goal is often raised in two areas of reform discussions. First is the issue of the adequacy of the benefit package. Over the last 35 years, much has changed in what is covered in private sector plans, making Medicare's coverage inadequate in comparison. Lack of prescription drug coverage and no limits on cost sharing are two of the most important of these differences.

Second, given that much of the private sector has shifted to managed care, would similar changes to Medicare be appropriate as well? The original goal of assuring “mainstream care” was to provide access to high-quality care. Given the dissatisfaction of many with managed care and the current flux in the delivery system, does putting Medicare beneficiaries in managed care mean keeping up with the times or subjecting beneficiaries to the problem-plagued system the rest of us face? Does managed care in its present form represent an improvement in the delivery of care? This key issue in the debate relates to how much effort should be placed on using private plans to serve the Medicare population.

### **Commitment to Pooling Risks**

One of Medicare’s accomplishments is that the very old and the very sick have access to the same basic benefits as younger, healthier beneficiaries. Although there is certainly room for improvement, Medicare is insurance that is never rescinded because of the poor health of the individual. In fact, by expanding coverage to persons with disabilities in 1972, Medicare redoubled its commitment to insuring those who are most in need. Further, the premium for Part B, which is the contribution that most enrollees make while enrolled in Medicare, is the same for all beneficiaries regardless of age or health status.

In the private sector, even when there is a commitment to sharing risks, risk-pooling at the same level available through traditional Medicare is difficult to achieve. When individuals can move from plan to plan, insurers face a strong incentive to seek those who are just a little healthier on average. In that way, plans can offer better ser-

vices to their clients for a given price. This is good for some enrollees, but the breakup in the risk pool can be extremely detrimental to persons with the greatest needs.

Consequently, this goal is likely to come into conflict with options to rely upon private insurance plans to serve the Medicare population and to allow such plans to tailor their benefits so as to attract particular groups. By the very nature of such “choices,” the risk pool is split, and as yet, efforts to adjust for risk differences have fallen short. Do the advantages of private options outweigh the benefits of risk-pooling?

### **Additional Help to Those in Need**

By making Medicare a benefit available to all who qualify and setting contributions on the basis of ability to pay, Medicare also meets the principle of “social” insurance. When Medicare began, persons without insurance—and hence the most likely to gain from its introduction—tended to have lower incomes and to be the oldest among those age 65 or over. One of the reasons for a public commitment to health care for the elderly and disabled is to achieve some equality in services regardless of ability to pay.

This goal is currently at issue concerning expansion of benefits: Should improvements be universal or limited to those with the fewest resources? Medicare was introduced as a universal program, even though some would benefit more than others, as a way to achieve and retain broad support. Thus, even in the beginning of the program, the universal nature of the legislation created some who benefitted more than others. Are the benefits of this proven approach sufficient to justify the higher costs of a universal benefit, compared with a more targeted one?

## CHALLENGES FACING MEDICARE

A broad range of issues will be faced by the Medicare program as the baby boom ages and as the overall health care delivery system evolves over time. The two major challenges facing Medicare are to some extent contradictory: the need to deal with the inadequacy of the benefit package and the desire to prevent the program from consuming too large a share of our Nation's resources. This latter concern has diminished in urgency as the outlook for Medicare's future has improved since 1997. Projections from the 2000 trustees' reports (Board of Trustees of the Federal Hospital Insurance Trust Fund, 2000; Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, 2000) indicate that Medicare's share of the gross domestic product (GDP) from both parts of the program will reach 3.95 percent in 2025, up from 2.29 percent in 1999. This still represents a substantial increase in the projected GDP devoted to care—a 72.5-percent rise—but the number of persons projected to be served will have increased over the same period by 78.5 percent. At that time, Medicare will serve about one in every five Americans. Thus, a legitimate concern is to what extent it is desirable to drive spending lower, and if so, by how much? Improving the adequacy of benefits will also require an additional commitment of resources. It is unlikely that reforms to the Medicare program will be sufficient to eliminate all need for further tax contributions over time; indeed as a society, we may well decide to devote substantial additional resources to Medicare.

### Improved Benefits

It is hard to imagine a “reformed” Medicare program that does not address two key areas of coverage: prescription

drugs and a limit on the out-of-pocket costs that any individual beneficiary must pay. When Medicare was passed in 1965, the benefit package was reasonable, compared with other available private insurance. But over time, private insurance has expanded upon what is covered, while Medicare has changed little.

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

Without a comprehensive benefit package that includes those elements of care that naturally attract sicker patients, viable competition without risk selection among private plans (either in the current Medicare+Choice or its successor) will be difficult to attain. For example, the problems with the current Medicare+Choice system relate more to affording the rising costs of the additional benefits they add to the basic package than to the costs of Medicare-covered benefits. In particular, private managed care plans that have been offering prescription drug benefits find that they attract sicker patients, and

consequently they have been cutting back on these benefits (Gold et al., 1999). If all plans had to offer a basic prescription drug benefit, for example, and payments from Medicare to these plans increased to reflect that new benefit, competition might actually improve. Certainly this would be a fairer approach than simply giving Medicare+Choice plans more money to retain such benefits while not providing them for persons in traditional Medicare.

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

### **Prescription Drugs**

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

### **Cost-Sharing Changes**

Expansion of coverage to drugs alone is unlikely to be enough to entice enrollees in traditional Medicare to forego supplemental plans, because cost sharing under the current program rules can be very high.

In particular, the lack of an upper-bound limit on what people can owe causes problems. Adopting a more rational Medicare cost-sharing package would not have to be extraordinarily expensive if it increased cost sharing in areas that are low now, compared with private plans, while reducing the unusually high hospital deductible and adding stop-loss protection (Moon, 1996b; Gluck and Moon, 2000). Medicare's cost sharing could be brought more in line with what the rest of the population faces without resorting to full first dollar coverage. The difficulty with this approach is that liabilities for cost sharing would rise for many beneficiaries, while the protections would apply to a more limited group (although the amount protected would be substantial), creating more "losers" than "winners." Many of those who would pay more to Medicare could still come out ahead of the current system, however, by not paying the \$1,000 or more per year they now spend on medigap. And as medigap becomes more expensive, this type of change will become more attractive over time.

### **Other Benefit Issues**

A number of special problems face the disabled Medicare population under age 65. The 24-month waiting period before a Social Security disability recipient becomes eligible for coverage creates severe hardships for some beneficiaries who must pay enormous costs out of pocket or delay treatments that could improve their disabilities. In addition, a disproportionate share of the disability population has mental health needs, and Medicare's benefits in this area are seriously lacking.

Finally, the need to provide protections for low-income beneficiaries has still not been well met by the current system. Income cutoff levels for eligibility for special

benefits offered through Medicaid are restrictive, excluding many modest-income beneficiaries. Participation in the qualified Medicare beneficiary and related programs is low, in part, because they are housed in the Medicaid program and thus tainted by its association with a “welfare” program. Further, States, which pay part of the costs, tend to be unenthusiastic about these programs and likely also discourage participation. Beneficiaries alike in all ways except State of residence may face very different levels of protection.

### **Greater Efficiency in Care Delivery**

Health care spending under Medicare has risen over time as a result of growth both in the numbers of persons served by the program and in the per capita costs of providing care. But most of the attention on ways to slow Medicare’s growth has focused on expenditures. Although there is general agreement that changes to enhance Medicare’s efficiency and effectiveness are reasonable concerns, the more difficult question is how this should be done. Can we expect the private market to do better in the future at controlling health care costs than Medicare? Two claims are generally made for why the private sector might be more effective. First is that by encouraging plans to compete with each other, they might find innovative ways to limit their costs. And second, private plans are simply more likely to be efficient. Much of the debate on Medicare’s future centers on assessing these claims.

To make price competition among private plans work, proposals call for beneficiaries to bear higher premiums if they choose more expensive plans—an approach often referred to as “premium support.” The theory is that beneficiaries will become more price conscious and choose lower cost

plans if they have economic incentives to do so. This in turn will reward private insurers that hold down costs. Evidence from the Federal employees’ health care system and the California public employees’ system indicates that this approach can discipline the insurance market to some degree (U.S. General Accounting Office, 1993; Merlis, 1999). Studies that have focused on retirees, however, show much less sensitivity to price differences (Buchmueller, 2000). Older persons may be less willing to change doctors and learn new insurance rules in order to save a few dollars each month. Thus, it is not known if such a system will work for Medicare.

In addition, premium support may generate a set of problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients; it is not only disruptive, it can raise costs of care (Weiss and Blustein, 1996). And if it is only the healthier beneficiaries who choose to switch plans, the sickest and most vulnerable may end up being concentrated in plans that become increasingly expensive over time. Further, private plans by design are interested in satisfying their own customers and generating profits for stockholders. They cannot be expected to meet larger social goals such as making sure that the sickest beneficiaries get high-quality care. If such goals remain important, additional protections will have to be added to a premium support approach to balance these concerns.

Competition among private plans does not magically lead to lower costs. It is what plans do to reduce costs that matters. So how does Medicare compare with the private sector? Health care cost increases arise from three main sources: the price charged for services, the basic efficiency of the delivery system, and the number of services delivered.



Medicare has always been competitive in terms of holding down the price it is willing to pay for services, particularly in the key areas of hospital and physician payment. Studies have consistently indicated that Medicare historically has paid hospitals below their costs (Prospective Payment Assessment Commission, 1997), and the fees that Medicare pays for physician services tend to be below even what insurers who demand discounts pay (Zuckerman and Verrilli, 1995). In other areas, such as home health care and skilled nursing facilities, Medicare needs to do better and is in the process of developing and instituting prospective payment systems. At the least, private plans do not have an advantage in terms of pricing services.

When examining the efficiency of alternative approaches, Medicare scores very well in terms of administrative costs, averaging less than 3 percent of the cost of providing care (Board of Trustees of the Federal Hospital Insurance Trust Fund, 2000; Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, 2000). This track record is substantially better than the private sector. Administrative costs are not the only issue, however; in fact, it is possible to spend too little on oversight and management, resulting in other inefficiencies. Consider efforts to reduce fraud and abuse. Until 1996, Medicare had few resources to devote to such activities, but now the program can use trust fund monies to finance investigations that promise to save the program money. And although many analysts were initially skeptical, reductions in spending increases targeted by anti-fraud efforts suggest these activities have been quite successful in the basic Medicare program.

On the other hand, private plans have had a traditional advantage over Medicare in the area of efficiency because they can be arbitrary. That gives them the flexibility

to react quickly. That is, if they see a troubling pattern in service delivery, they can simply decline to renew contracts with doctors or hospitals. Medicare needs more flexibility in this regard, but it is likely that it will always have to meet higher standards of due process. This constraint may make Medicare more costly in some areas, but it also protects providers and beneficiaries.

The most important source of growth in health care costs arises from increases in numbers of services used and particularly from the diffusion of new technology, often referred to as “intensity” of service use. Both Medicare and private plans have difficulty in sorting out appropriate and inappropriate care. Studies that have looked at these issues concluded that there is a substantial amount of overuse of care (e.g., Chassin et al., 1987; Winslow et al., 1988). But difficulty arises in pinpointing where it is occurring and how to control it. Absent good effectiveness and quality studies, many providers and patients view access to unlimited tests and procedures as one way to ensure quality. Americans have a strong belief in and taste for high technology.

One of the key issues is who patients trust to help them make decisions on the use of services. In the “old days” of traditional fee-for-service medicine and little oversight, the decision was largely left to physicians and patients. Their inclination, it is believed, was to use too many services. This criticism is often lodged against the traditional part of Medicare.

Managed care organizations (MCOs) ideally are designed to address these issues because they take on the responsibility for the cost of all health care services for a patient and are paid a predetermined amount for that patient. Positively managing care can be done through careful coordination and oversight, although few insurers have devoted the time and effort necessary

to do this well, and many loosely organized plans do not have the means to do so (Center for Studying Health Care Change, 1999). Another approach is to place barriers in the way of getting care: requiring pre-approval for tests and procedures, requiring referrals before someone can see a specialist, or denying certain services, for example. Poorly managed care can mean underservice and undesirable rigidities in allowing access to care. Moreover, the public has become increasingly skeptical of active efforts in this area. The patients' bill of rights movement is one indication of interest in limiting how arbitrary private plans can be. Over time, progressive plans may be able to improve techniques for managing care, establishing a case for further privatization, but the evidence does not support greater effectiveness of private plans, compared with traditional Medicare. And private plans will have to overcome their clients' skepticism about the motivation behind limits on service use.

### **More Cautious Approach**

It is useful to think about reform in terms of a continuum of options that vary in their reliance on private insurance, with periodic reassessments of how well such efforts are working. Few advocate a fully private approach with little oversight; similarly, few advocate moving back to 1965 Medicare with its unfettered fee-for-service and absence of any private plan options. In between are many possible variations. And even for those who would make fewer structural changes, this does not mean that nothing needs to be done with traditional Medicare. Indeed, more emphasis is necessary to find ways to improve efficiency and help coordinate care short of relying on private plans.

Further, although differences in approach to reform may seem technical or obscure, the details will determine how the program will change and how well beneficiaries will be protected. Perhaps the most crucial issue is the role of traditional Medicare. Under the current Medicare+Choice arrangement, beneficiaries are automatically enrolled in traditional Medicare unless they choose to go into a private plan. Alternatively, in premium support approaches, traditional Medicare would become just one of many plans that beneficiaries choose among—likely paying a substantially higher premium if they choose traditional Medicare. But whatever changes are made, traditional Medicare is likely to be the “default” plan for many years. Some beneficiaries with substantial health problems will view private plans as unrealistic options. Older beneficiaries may simply be reluctant to adjust to a new system of care. Thus, there needs to be a strong commitment to this part of the program. For the time being, there cannot and should not be a level playing field between traditional Medicare and private plans, because this would likely lead to traditional Medicare being priced beyond the means of many. Penalizing those who remain in traditional Medicare would run directly counter to the goal of protecting the most vulnerable.

The usual defense of a “choice of plans” approach is that payments from Medicare will be adjusted for risk and that will solve any problems that beneficiaries face including keeping the premiums for traditional Medicare in check. But there is considerable work left to be done on improving such risk-adjustment mechanisms. The solution to risk selection is to find ways that give plans incentives to treat sicker beneficiaries. But thus far, private

plans have resisted a greater reliance on such risk adjustment, and even experts often question whether the tools at hand are sufficient to move quickly to a greater reliance on private plans.

Further work is also needed on other provisions of the Balanced Budget Act of 1997 (BBA) if private plans are to play a larger role in Medicare. For example, private plans are currently up in arms over the levels of payment established under the BBA to make managed care a money-saver for Medicare. They want to maintain the extra benefits they have been able to offer as a result of overpayments. And planned demonstrations of competitive bidding have met opposition from insurers and beneficiaries alike (Nichols, 2000). Consumer education efforts also need to be more successful if beneficiaries are to make sound choices about private plans.

Better norms and standards of care are also needed if we are to provide quality of care protections to all Americans. Investment in outcomes research, disease management, and other techniques that could lead to improvements in treatment of patients will require a substantial public commitment. This cannot be done as well in a proprietary, for-profit environment where dissemination of new ways of coordinating care may not be shared. Private plans can develop some innovations on their own, but in much the same way that we view basic research on medicine as requiring a public component, innovations in health delivery also need such support. Further, innovations in treatment and coordination of care should focus on those with substantial health problems—exactly the population that many private plans seek to avoid.

Finally, it is not clear that there is a full appreciation by policymakers or the public at large of the consequences of a competitive market. If there is to be choice and competition, some plans will not do well in

a particular market, and they will leave. Withdrawals should be expected; indeed, they are a natural part of the process of weeding out uncompetitive plans that cannot attract enough enrollees or establish good provider networks. In fact, if no plans ever left, that would likely be a sign that competition was not working well and that plans were overpaid.

But plan withdrawals result in disruptions and complaints by beneficiaries—much like those now occurring under the Medicare+Choice withdrawals that have occurred over the last 3 years. In those cases, beneficiaries who must change plans may have to choose new doctors, learn new rules, and/or pay more for extra benefits. In response, there has been strong political sentiment for keeping Federal payments higher than a well-functioning market would require, reducing any potential savings from relying on private plans.

## **Other Reform Issues**

Although most attention on reform focuses on restructuring options and the benefit package, other key issues also arise, including age of eligibility, beneficiary contributions, and the need for more general financing. Even after accounting for changes that may improve the efficiency of the Medicare program through either structural or incremental reforms, the costs of health care for this population group will still likely grow as a share of GDP. That will mean that the important issue of who will pay for this health care—beneficiaries, taxpayers, or a combination of the two—must ultimately be addressed.

### **Age of Eligibility**

Proposals to raise the age of eligibility for Medicare are offered to reduce the size

of the beneficiary population. Life expectancy has increased by more than 3 years since Medicare's passage in 1965, offering one justification for delaying eligibility (National Center for Health Statistics, 2000). And if people do begin to work longer, delaying their retirement, this option becomes more viable.

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

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

### **Beneficiaries' Contributions**

Some piece of a long-term solution probably will (and should) include further increases in contributions from beneficiaries beyond what is already scheduled to go into place. The question is how to do so

fairly. Options for passing more costs of the program onto beneficiaries, either directly through new premiums or cost sharing, or indirectly through options that place them at risk for health care costs over time, need to be carefully balanced against beneficiaries' ability to pay. Just as Medicare's costs will rise to unprecedented levels in the future, so will the burdens on beneficiaries and their families. Even under current law, Medicare beneficiaries will be paying a larger share of the overall costs of the program and more of their incomes in meeting these health care expenses (Moon, 1999).

One option is an income-related premium where higher income persons pay a greater share of Medicare's costs. Tying premiums to income makes sense on grounds of equity, but may be difficult to achieve in practice. Administrative costs would have to rise substantially. But more important, such approaches generate only limited new revenues unless the income thresholds are set very low. There simply are not enough high-income elderly persons for this option to "solve" the problem.

An alternative income-related approach would treat Medicare benefits—all or in part—as income and subject to the Federal personal income tax. This is analogous to taxing Social Security, although more complicated because these benefits are received "in kind" and are not traditionally viewed as income. Taxation of benefits would not only raise revenue but also make beneficiaries more aware of the "value" of Medicare benefits. However, this option would add considerably to Medicare's complexity, and critics argue that it is unfair to tax some in-kind benefits and not others.

### **Additional Public Financing for Medicare**

Ultimately, the issue of who will pay must be divided between beneficiaries and tax-

payers. Even with higher beneficiary contributions and more efforts at improving the efficiency of the program, the long-run costs of Medicare will require additional public funds (Gluck and Moon, 2000). Because the population currently served by Medicare will grow to more than one in every five Americans, as a society we will need to face up to the costs of financing health care, either through the Medicare program or privately. Reducing Medicare's population or benefits will shrink government liabilities but do little to change the liabilities that society must face.

## CONCLUSION

Medicare is likely to face many new challenges in the future, but it makes sense to consider previous accomplishments and the goals set in place in the original legislation in assessing what should be done next. Medicare cannot and should not remain the same as it was in 1966 or 1999, but reform efforts need to be carefully considered as to what should be done and at what pace.

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