Commentary

Repairing the Medicare Act of 2003: Confronting Urgent Realities

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In November of last year, after months of partisan warfare, Congress finally passed what was then called the Prescription Drug, Improvement, and Modernization Act of 2003, now known as the Medicare Modernization Act (MMA)—a bill that is meager on both drug benefits and “modernization.” The latter deficiency—basically the absence of fundamental, responsible fiscal reform—is more worrisome. Without it, the government will hardly be able to print enough money to sustain Medicare through the first third of the 21st century. Unfortunately, rancor over the bill persists with strident calls for its repeal and a return to good old, unadulterated, “traditional” Medicare.

Origins of Medicare’s Bankruptcy

Repeal of the bill would be reckless on two counts:

1. Traditional Medicare is bankrupt not only financially but also structurally, because of its archaic methods of financing and reimbursement and its defined benefit structure. Alone, it is incapable of responding to health care’s technological evolution and America’s looming tectonic demographic shifts.

2. Time is short; Congress cannot afford to start over. The “baby-boomers” will start joining Medicare in 2011 and will continue to inundate it for the following 19 years with an impact underestimated by even the most pessimistic pundits.

A snapshot of Americans and their health care from the year 1966 helps us understand the current predicament. Back then, 5.2 working Americans were contributing payroll taxes for each Medicare beneficiary; today that ratio has declined to 3.9:1. In 1966, each 65-year-old lived only another 14.6 years on average. Today, a 65-year-old lives 20% longer, for an average of 17.6 additional years.

The original financing mechanism was predicated on those demographics as well as on proportional spending for various health care services in the 1966 era. Part A hospital services, which then accounted for 76% of total costs were, and continue to be, fully financed by payroll taxes paid into the Medicare Hospital Trust Fund. By 2002, those services accounted for only 58% of costs. In 1966, in contrast, Part B services accounted for only 24% of costs, 25% of which were financed by premiums paid by beneficiaries and 75% by general revenues (i.e., income taxes). By 2002, Part B’s share had risen to consume 42% of spending; this means that non-Medicare taxes now finance nearly a third (32%) of all Medicare costs, twice the proportion relied upon in 1966.

The traditional Medicare defined-benefit plan was also predicated on those 1966 proportional costs: they were richest for Part A hospital services and more modest for Part B outpatient and physician services while ignoring what were then negligible drug costs.

Finally, provider reimbursement in 1966 was based upon a fee-for-service model. As that model developed fault lines, a series of fixes were attempted:

- 1983: the Diagnosis-Related Group (DRG) prospective payment system for hospitals
- 1989: the Resource-Based Relative Value Scale (RBRVS) for physician fees
- 1997: the Balanced Budget Act (BBA), a combination of prospective payment schemes for outpatient services, specialty hospitals, and home health services—as well as ill-disguised price controls on hospital and physician services

All three initiatives have succeeded only in provoking annual skirmishes between Medicare and its providers and have done little to control costs.

Given this history, is there enough in the 2003 Act upon which to build? A bill that was so vehemently opposed by both the Classic Conservative Trent Lott (R-Miss.) and the Venerable Liberal Lion Ted Kennedy (D-Mass.) can’t be all bad . . . and it’s not.

The most positive news is that the MMA of 2003 does provide 10 million senior citizens with their first-ever drug coverage, while another eight million people at or below the poverty line will keep their existing coverage. Employer tax credits will ensure that most of the 13 million elderly people who currently have an employer-sponsored benefit will retain it, and those unfortunate few with huge costs will be covered.

Two vulnerable, and costly, groups do remain ill served, however: the seven million near-poor seniors with incomes just above the poverty line and people with mid-level drug expenses between $2,250 and $5,100, the infamous “doughnut hole,” in which not a cent is covered.

No Need to Reinvent the Wheel

Helping these underserved constituencies will require supplementing the aging traditional Medicare with more functional and durable enhancements. For a prototype of just such a model, we need only turn to a decades-old, soundly financed,

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and hugely popular All-American Plan. This plan is offered by a nationwide, heavily unionized employer with more than two million retirees. All retirees and their spouses are offered the choice of traditional Medicare or a variety of private plans with richer benefits, including drugs. Under its defined contribution (i.e., Premium Support) format, the employer contributes a fixed percentage of the premium for a chosen plan.

For example, a retiree pays only $75 for a $300-a-month policy and $100 for a $400-a-month policy. To control drug costs, the employer relies not upon its own mass purchasing power but, instead, upon each private plan’s own private pharmacy benefits manager (PBM). This exemplary employer is none other than the federal government itself, through its Federal Employees Health Benefits Program (FEHBP).

Extending that model to 40 million senior citizens, though, can be accomplished only by increasing revenue, reducing costs, or both. Traditional Medicare, by its very nature, is no longer up to either task.

Increasing Revenue . . .

Here is the sobering reality: Medicare is flat broke, and all three of its revenue sources are essentially “maxed out.” Although some money does remain in the Part A Hospital Trust Fund, for years Medicare has borrowed, without repayment, from general revenues to help pay for Part B services. The tab in 2003 was $82 billion. Furthermore, as current workers become less optimistic about their future Medicare benefits, they are not in the mood to increase their contributions to the second revenue source—the Medicare payroll tax.

Finally, Medicare beneficiaries themselves already pay a monthly Part B premium of $800 a year. The 2003 Act, for the first time, will impose means testing by raising the premium for wealthier seniors, effectively compromising that source as well.

. . . or Reducing Costs

As far as costs are concerned, one potential solution lies in adjusting the benefit mechanism itself. In this area, traditional Medicare is intrinsically obsolete because its defined benefits were set back in 1966, when hospital costs were paramount. As costs shifted to outpatient services, Medicare was politically compelled to fund these services without cutting the hospital benefit. Similarly, until now, Medicare has been unable to include drugs within its defined-benefit structure. In contrast, the FEHBP Premium Support mechanism provides alternative plans that do include drugs.

Similarly, the traditional Medicare fee-for-service method of paying health providers is inherently unable to control spending because neither physicians nor hospitals are held responsible for their patients’ total medical costs.

A PIVOTAL ROLE FOR HMOs AND PPOs

Private health plans, namely Medicare health maintenance organizations (HMOs) and preferred provider organizations (PPOs), in assuming responsibility for all medical costs of their enrollees, do offer real opportunities for savings. That potential is leveraged by the fact that more than 80% of Medicare’s costs are incurred by the sickest 20% of enrollees, a population whose costs have been successfully managed by HMOs for a decade with the use of Disease State Management (DSM) Programs. Traditional Medicare, in contrast, began experimenting only two years ago with small DSM demonstration projects that it hopes will duplicate this success.

In the meantime, HMOs have also been stymied by a dysfunctional traditional Medicare reimbursement method that ignores an enrollee’s health status and that is determined mainly by the enrollee’s age, sex, and county of residence. The latter is a perverse incentive because it is linked to Medicare’s fee-for-service costs in each county; these costs vary almost two-fold nationally and even within individual states.

As an example, an HMO is paid $869 a month for an average enrollee in Dade County, Florida, and only $335 a month for an enrollee in several other Florida counties where physicians and hospitals historically have delivered less costly health care. Now both of these inequitable methodologies are changing.

Before 2003, for instance, Medicare paid an HMO the same amount for a 65-year-old Boston marathoner as for a 65-year-old Boston diabetic patient with congestive heart failure following a heart attack. In 2003, however, Medicare began the key transformation of paying HMOs based on each enrollee’s health history. By 2007, therefore, the Medicare HMO will receive 2.5 times as much for the patient with diabetes or, conversely, only 40% as much for the marathoner. This six-fold difference in payment more accurately reflects the actual costs of caring for the sicker enrollee. Furthermore, by 2007, those payments will not vary by geographic region.

The MMA also improves overall HMO rates, which were limited by the Balanced Budget Act of 1997 to 2% yearly increases between 1998 and 2002 while Medicare’s fee-for-service per capita costs rose by 18% over the same period. The combined incentives will stimulate HMOs’ courtship of elderly citizens who will join up, because contrary to popular rhetoric, senior members are rather fond of their HMOs. In fact, in 2001, more than 87% of 4.5 million Medicare HMO members who were given the choice decided to re-enroll.

TAMING DRUG INFLATION

Two contentious provisions of the MMA address drug costs. The bill stipulates that Medicare should rely upon private PBMs, as does the federal government for its nine million employees and retirees. The three largest national PBMs covering more than 200 million lives have sophisticated information systems that provide important quality features for accuracy and surveillance for overutilization and underutilization and adverse drug interactions. Opponents, in contrast, favor direct federal price controls.

A practical middle ground would be to emulate the Department of Veterans Affairs, the Department of Defense, and many state Medicaid programs by requiring individual PBMs to use their own enormous market influence to offer Medicare a variation of their “best price.” Such a mechanism would mandate that the Medicare price for any given drug be equal to or less than the best price offered by any of a PBM’s groups.

Second, the bill prohibits re-importation of drugs from other countries whose government-controlled prices are lower. Arguing that prices in the U.S. are too high, opponents favor
re-importation, a short-term fix that begs the real issue: that Americans are in reality subsidizing Canadian and European prices, which are too low. The ultimate solution involves modifying trade policy rather than using the temporary solution of a re-importation scheme. Because U.S. companies account for half the world’s branded pharmaceutical industry, an export tariff on drugs sent to developed countries would help to ensure that they pay their fair share of the costs of developing, producing, and distributing drugs.

The MMA also falls short in two other key areas. It is vague about the specifics of a Medicare formulary (which is crucial to its cost-effectiveness), and it is silent on defining standards for the entry of new drugs—standards that will need to be rigorous to maintain Medicare’s long-term fiscal integrity.

**PROTECTING TODAY’S BENEFICIARIES**

Four elements of reform are integral to strengthening Medicare’s financial position while providing a broad-based drug benefit for today’s beneficiaries:

- retaining traditional Medicare as a core benefit package
- continuing risk-based payments to new and existing private Medicare HMOs and preferred provider organizations (PPOs), which offer richer benefits, including, at a minimum, a core drug benefit
- converting to a defined-contribution (i.e., Premium Support) model, which encourages choice among those health plans as affordable alternatives to basic Medicare
- setting best price drug cost standards for all such plans.

**THE BOOMERS’ LENGTHENING SHADOW**

These four measures alone, however, will be inadequate to meet Medicare’s longer-term commitment to future beneficiaries. Closer examination of the impending baby-boomer avalanche highlights both the difficulty and the urgency of revitalizing its ability to do so. During the 1990s and continuing through this decade, Medicare’s annual enrollment growth has been minimal as two million seniors age in each year while a few less die.

Meanwhile, the ratio of workers to beneficiaries continues to be nearly stable; however, starting in 2011 and repeating each year through 2030, Medicare will be struck by a double whammy, as twice as many Americans—four million a year—become eligible for Medicare and simultaneously stop contributing payroll taxes when they leave the workforce. The effect: a net gain of 20 million beneficiaries inadequately amortized by a dwindling worker-to-beneficiary ratio, which by 2030 will shrink to 2.3:1 from today’s 3.9:1.1

**THE INEVITABLE, UNENVIABLE FIX**

The equitable but politically challenging solution is one thus far barely whispered in Congressional cloakrooms—incrementally increasing the Medicare eligibility age to 67, as has already been done for Social Security. Rhetoric to the contrary, this would not be in violation of the “sacred trust” of Medicare in 1966. Back then, Americans were promised 14 years of Medicare coverage. Even with an increase to 67 years, they would still have at least 15 years of benefits. Social Security’s age eligibility precedent was set in 1983, when Congress passed legislation that, in 2003, began the slow incremental eligibility increase from age 65 to 67. For Medicare, we will probably not have the luxury of a full 20-year lead, but there is precious little time to lose.

**REFERENCES**