URBAN INSTITUTE

MEDICARE BENEFICIARY COSTS: A CRUCIAL REFORM CHALLENGE

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MR. ROBERT REISCHAUER: Through the initial first Tuesday of the new millennium, this first Tuesday is being broadcast by C-SPAN and we'd like to welcome all the C-SPAN viewers. In addition, it will be Web cast by the Kaiser Network starting tomorrow. The Kaiser Network is a news summary and Web casting service that is sponsored by the Kaiser Family Foundation, and in addition to Web casts of events like this, it also provides a calendar of health policy events and news summaries called "The Daily Health Policy Report."

The topic that we've gathered here today to discuss is the growth of out-of-pocket spending by Medicare participants, particularly vulnerable beneficiaries. Medicare provides important, vital health insurance protection to the elderly and the disabled of this country, but the coverage that it offers is less generous than the insurance protection that many Americans receive, either from their employers or through the Medicaid program. Out-of-pocket costs, of course, consists of premiums that individuals pay for their policies, deductibles, co-insurance and co-payments and, of course, expenditures on those services that are not covered by insurance. And when we're talking about Medicare, that includes prescription drugs that are bought outside of the hospital.

The growing burden borne by Medicare participants is an issue that is receiving increasing attention in the policy debate as the cost of prescription drugs has begun to grow very rapidly, as supplementary coverage provided by employers to their retired workers begins to erode, as the cost of Medigap policies that are individually purchased has risen, and as other problems have arisen. This, of course, became apparent during the recent political campaign where both candidates offered prescription drug coverage for Medicare beneficiaries, and the President-Elect, in addition, suggested that Medicare should be expanded to have an out-of-pocket cap.

We have an outstanding panel of experts here to discuss these and other issues. The discussion will be led off by Marilyn Moon, who is a Senior Fellow at the Urban Institute, and until the middle of last year was a public Trustee of the Medicare program.

She will be followed by Stephanie Maxwell, who is a Senior Research Associate at the Urban Institute, and a former Senior Analyst at the Medicare Payment Advisory Commission, and Stephanie will summarize the report that she and Marilyn and several other individuals here at the Institute did with the Commonwealth Fund, which discusses these issues, and you all have a copy of this report on your chairs.

Following Stephanie's presentation, Mike Hash will discuss some of the consumer dimensions to this problem. Mike, until recently, was the acting Administrator of the Health Care Financing Administration, which is the government agency that runs both Medicare and Medicaid. Mike has also worked on Capitol Hill in important health policy roles, and with health policy alternatives.

Finally, John Rother, who is the director of Legislation and Public Policy for AARP, will provide his insights into this issue. So without further adieu, let me turn this over to Marilyn, who has kindly given me her seat.

DR. MARILYN MOON: But don't take my notes.

MODERATOR: And I--yes, and I will try not to take her notes. Okay.

DR. MARILYN MOON: Thank you. It falls to me, partially because I guess we have a shortage of space, to be the moderator today, so I guess I'll give myself lots of time and not much time to anyone else, but we're going to try to have, keep the presentations relatively short so that we can have a discussion, as is one of the goals of the first Tuesdays.

The Medicare beneficiary issues that we're going to talk about today really have a motivation, in the observation that I and other people have made, that it is often the case that people talk about spending on Medicare, and talk about it as unsustainable and the problems that are likely to arise in the future from Medicare costs, and they forget or fail to take into account in many cases the fact that often costs to beneficiaries will rise in tandem with the projected costs of Medicare. So we tried to do a fairly straightforward and simple look at this issue, and that's going to be the jumping-off place, and related to the other information you're going to hear. So I thought I'd set the stage a little bit, both for the motivation of the paper and a little bit of the technical stuff that you should know in terms of understanding what's going on here.

Medicare, as we all know, I think is likely to be a very important issue for the foreseeable future. Health care inflation increases in the use of care, and growing beneficiary population are all factors that people have talked

about, both in the campaign that just ended for the Presidency and in many of the Congressional campaigns; it is an issue much on the mind of many individuals. But, and even though the outlook has improved over time, Medicare will still grow to be a substantial share of the gross domestic product, if the projections that are made are correct. Stacy, if you'd put that first slide up there. This is just to illustrate three different trends using different years of the Trustee's Report, and that, the bottom line is the most recent one and, therefore, the most optimistic projection. 4.4 percent of GDP going to health care spending on seniors and disabled persons by the year 2025. That's up from about 2-1/2 percent right now, so it will be a substantial growth. In fact, it's at 72 percent growth in costs as a share of GDP, which is pretty big, but I would also remind you that we're going to have a 78 percent increase in the number of beneficiaries, for example, covered by the program.

Now, the paper we're discussing today is essentially takes the Trustee's Report, although we use 1999 because of the time it takes to get all the little pieces together, and although '99 does not look as good as 2000 on there, that's largely because of growth in the economy and the projections of actual spending are pretty much the same, so the numbers would not change much if we had started with 2000. And we essentially say, all right, we know what the rules are for Medicare, we know what the aggregate spending projections are, let's figure out what per capita spending projections are and then what that means, for something that we call beneficiary liability. Beneficiary liability is simply the cost-sharing and the premiums that individuals are required to pay to get their Medicare benefits. That cost-sharing liability is right now around 22 percent, just a little over one-fifth of the costs of the Medicare program are actually borne by the beneficiaries themselves, and it will rise over time to 2025 to about 25 percent of the costs of the program because of some changes in premiums.

Now, that's only part of the story, however, because as many of you who know about Medicare understand, the--there are two things that happen to that beneficiary liability that have to be taken into account before you can talk about actual out-of-pocket costs, and that is that many people have some insurance protection that reduces the liability that they have from Medicare's cost-sharing requirement, and that in many ways can help protect them, particularly if it's the generous employer-provided insurance that's subsidized for those individuals. So that would lower beneficiary liability a little bit.

But on the other side, we have things that will raise beneficiary liability when you're talking about out-of-pocket costs, and that is the beneficiary liability figures that you'll find in the paper only refer to Medicare-covered services,

and for people who have to buy prescription drugs who have other needs that are not covered by the Medicare program, there are substantial additional out-of-pocket costs. So we do those, essentially two types of adjustments to this model to come up with an out-of-pocket estimate, and we think that we're relatively conservative in that. For example, many people believe that employer-sponsored insurance is going to decline over time. We have not assumed that. We've tried to just take things very straightforwardly and project them into the future to give a sense of what out-of-pocket spending could be and to do it on the conservative side, that is, to make sure that we're not overstating the numbers, because as you'll see in a few minutes, they're pretty mind-boggling all by themselves. And the only way in which we really differ, because we use the rate of growth of per capita Medicare spending for most of our projections, is that prescription drugs are rising, as everyone knows, much faster than most other forms of health care spending, and so for 10 years we project into the future a higher rate of prescription drug spending to adjust for that.

This report actually is the second round, if you will, of reports that we've done for the Commonwealth Fund, and updating the numbers that we had done in the past. Since things look better from 1998 to 1999, we expected in some ways, that out-of-pocket spending would look better. But when you do better adjustments, as we were able to do this year for the components of spending, in particular for prescription drugs, it doesn't turn out to be that way. And so we think that it's still important to understand that you need to look carefully at what the impacts will be on individuals. Also quite different than what we were able to do in the past, we have added cohort groups to look at the range and variation in spending that's likely to occur for this population. A later paper will, that's underway now, is going to look at options for changing the Medicare program that will have impacts on beneficiary spending and we will hopefully have that done in the near future, but that gives you a little bit of something to look forward to. And I'll let Stephanie tell you some of the results from the paper.

MS. STEPHANIE MAXWELL: Thank you. We have two main data slides, and we'll only burden you with those. You can look in the paper for all of the other ones. But before getting to those, wanted to give a little more of the lay of the land, like Marilyn was doing, about beneficiaries and about out-of-pocket spending.

First of all, if we look at this pie chart, we see that, all in all, things don't look so bad in terms of the insurance coverage that Medicare beneficiaries had, but we see that only about 10 percent of Medicare beneficiaries are only in that program. They don't have other supplemental insurance, and by that I mean in the fee-for-service program. We have a good share that are

in the Medicare Plus Choice managed care plan, that are in the various additional plans, or have additional coverage through any of the various Medicaid plans. So on one hand that looks good, but it's a little more rocky, a little less stable underneath that. We've all followed the Medicare Plus Choice issues. There's been a lot of market dynamics as well as program dynamics that have led to this 17 percent being a rather optimistic number. As plans are pulling out of the market, we have a smaller percentage than that that are actually in the managed care plans that provide not only the cost-sharing protection, but coverage of other services. So we could turn and say that, well, at least we have a third that are in the employer-sponsored plans, which traditionally are very solid and good plans, but the trends have been somewhat more negative rather than positive on that front, too. Not only are the retirees being asked to pay for greater and greater shares of the premiums for those plans, but the cost covering range of services that they cover have been declining a bit as well. They are in good stead, though, at least if you compare them with the individually purchased supplemental plan people. They not only cover the full price of their premium, but being on the individual market, those premiums are more expensive also. Often, many of these plans also are simply of less insurance value than the employer-sponsored plans. Now, the Medicaid coverage, certainly Medicaid is a stable program, maybe compared to some of the private sector plans, but very small changes in income can lead quickly to a beneficiary not being eligible anymore for the Medicaid coverage. So although the program is itself might sound stable, an individual circumstance can change quite traumatically under their Medicaid coverage. Go to the next slide.

Wanted to also give a little more lay of the land before getting the data slide about exactly the components of out-of-pocket expenditures. As Medicare, as Marilyn was talking about, the Medicare liability are basically these lower two pieces of the pie. Now, if we did this pie with basically all of our out-of-pocket expenditures rather than the Medicare beneficiaries, we would see that our liability and out-of-pocket would probably be close to one in the same. But in this circumstance, we have for the Medicare beneficiaries, about two-thirds of their out-of-pocket costs go, in fact, to non-covered services or to plans that cover their non-covered services, or for their cost-sharing. And in a way, you can see the size of that as an indication of the extent of the limitation of the traditional Medicare benefits plan. Next slide please.

In this study, we wanted to really highlight some of the different populations and their different cost experiences. We wanted to create groups that are different in terms of their health status and their insurance status. Those are two key things in our groups here, because of their impact on spending.

I'm not going to go through all of the numbers here, but what we are showing are the projected out-of-pocket spending of the range of different population groups in this year and in 2025. We're talking in terms of $2,000, so that accounting for regular price inflation, but the growth accounts for the Medicare and the other medical care inflation as Marilyn was talking about. I think there's two particularly interesting points about this. First of all, we have incredibly big variation in the out-of-pocket expenditures now and as projected for the different population groups. The two most striking differences are in groups that are somewhat similar. In the last two sets of bars, we're looking at Medicaid women who are actually in the QMB Program in Medicaid, and we're comparing them with the-- with other elderly women who are low income, just above the Medicaid eligibility line, and in poor health. We see that although their liability numbers, as you can see in the paper are somewhat similar, the out-of-pocket costs are dramatically larger for that group that doesn't necessarily have additional coverage, whereas people that have the Medicaid protection have dramatically lower out-of-pocket costs.

A second interesting point is the, Marilyn was touching on the differences in the projections of costs that we had in the model. We project that drugs will grow at about 10 percent, which is actually a very conservative projection. Most of the studies have shown that drugs have been running the double-digit range during the 1990's and will continue to do so. And another very conservative aspect in these numbers is that we projected that the various supplemental plans that people are in will grow at the rate of Medicare. We saw in the prior slides that these plans account for about a third of people's out-of-pocket costs, and if anyone's looked at their plan increases for this last year, you'll probably see that your plan, as well as ours, have grown more than a few percent. So I think the interesting points are both that, although our numbers are quite conservative, they're also quite high, and they're quite high for certain--some groups, and for other groups, if you look only at the overall elderly group, it has a fairly modest story. It's important to look at the different groups to highlight the really, almost untenable amount of spending that some elements of the population would be paying in the future. Next slide.

It's a little more meaningful though, I think, to talk about the numbers in terms of income. Although the numbers are high, in terms of actual dollars, this looks at the out-of-pocket spending as a percent of income, and the bottom line here is that the costs are growing much more quickly than the income is, and the most dramatic number, as you see, is at the end. 72 percent is the projected out-of-pocket spending as a share of income among this group of elderly low-income women in poor health. And at that rate, there's room for grocery money but really not much else. The group next to

them that have Medicaid protection, if they didn't have that protection, their share would be up similar to the group next to them.

I think it's also meaningful, I do a little more math and I add 25 years to my age and I look around in the audience, and 25 years to many of the ages in the audience, and it's also meaningful to think that these projected numbers will be our numbers. And then as we look to refinements and changes in the programs, it is going to be increasingly important to be focusing a bit on the beneficiaries' perspective, and on their burdens and the components of their burdens, as well as the overall macro-integrity of the program. Turn it over to Mike. Thank you.

MR. MICHAEL HASH: Thank you. Good afternoon. This paper, I think for all of us, confirms once again the fact that the financial burden that Medicare beneficiaries face, both from cost-sharing associated with the program as well as for non-covered services, are significant, growing, and more difficult in the sense of options for protecting a beneficiary's financial liability. The paper, of course, highlights, I think in a very dramatic way, the significant health care expenditures that sub-populations or cohorts of the Medicare beneficiary population face, and that's why it's a particularly valuable contribution in that it shows that individuals without supplemental insurance or those single women who are over 85 and in poor health are particularly at risk for the out-of-pocket expenses, both from the program itself and for the non-covered services they may need.

All of us, I think, in this room also know that lack of protection or coverage for insurance in the health area has consequences. The failure to have access to health insurance means that people do, in fact, forego needed health care services, access is reduced for those individuals, so there are very real consequences associated with a lack of protection for health care costs and out-of-pocket costs. Regrettably, the options that are available to beneficiaries to protect themselves from high out-of-pocket expenditures are not expanding. In fact, in a number of critical areas as Stephanie, I think, alluded to in her remarks, options are becoming less adequate, more expensive, and in some cases, not available at all.

Some of you may have seen Milt Freudenheim's piece yesterday--Sunday, I guess it was, in the "New York Times," where he was chronicling the decline of employer-based coverage, again, a fact that Stephanie's paper and comments remarked upon. Over the past six years among very large employers, those employing more than 500 people, the coverage has dropped, employer coverage has dropped from about 40 percent of all large firms to less than 25 percent. So less than one in four people who retire from large firms will have a post-retirement coverage. Many of those who

do have fortunately retained employment-based retirement coverage are finding higher premiums, deductibles, and that benefits, of course, can be capped and limited in other ways. Again, as Stephanie mentioned, Medicare Plus Choice Program, which had offered the promise of expanding protection, both for cost-sharing and for non-covered services, is having its own difficulties, suffering from significant withdrawals of participation or reductions in geographical service areas. Remaining plans in the Medicare Plus Program, Plus Choice Program have significantly increased premiums as well. For example, average premiums have gone from '98 to 2000 from about $34 a month to something like $84 a month, which is a very significant growth in out-of-pocket premiums for Medicare Plus Choice plans.

The private supplemental market, again as Stephanie alluded to, is also not a stable one. Prices are increasing, it's subject increasingly to adverse selection, average premiums are now in excess of $100 a month, and coverage is quite limited, the insurance value of those products is, as again Stephanie alluded to, not very adequate in many cases. And finally, the special assistance that's offered under, through the Medicaid program, either to dual eligibles or to individuals who qualify for the qualified Medicare beneficiary program, whether special low-income beneficiary program. Those latter two programs, the QMB/SLMB programs suffer from very poor participation rates, less than 50 percent in both of those programs, and that reflects a need obviously for a much more aggressive outreach effort.

What can be done in the short run about enhancing beneficiary protection for these growing out-of-pocket expenses? Well, it's important to remember that about 85 percent of all beneficiaries remain in the traditional fee-for-service program, and therefore, they really do face the highest, both cost-sharing liabilities as well as the non-covered service fees. And those are expanding, as Marilyn and Stephanie's paper shows, over the next 25 years. One of the things that's been going on in the short run, with respect to Medicare beneficiaries and their access to coverage, has been a targeted national education program for Medicare beneficiaries, recognizing that many of them are unaware of some of the protections that exist out there today. You may be aware of the so-called National Medicare Education Program. It's now about $100 million a year program. It involves a multi-faceted approach to providing comparative and useful information to beneficiaries, including a handbook called "Medicare And You" that's mailed to every Medicare beneficiary household. There is a 1-800 telephone number for Medicare beneficiaries with customer service representatives who are trained on Medicare questions and answers. There is a Web site, which is gaining increased attention and actually notoriety, in the sense of awards, it's called Medicare.gov. That Web site provides an increasing amount of comparative information about private health plans, about

Medigap, and in fact, most recently about access to subsidized prescription drug programs for the Medicare beneficiary community. I might say in passing, though, that that program of education through those various outreach efforts suffers from a lack of a stable financing source. The original idea was to peg financing for this to a user fee that health plans who participated in Medicare Plus Choice paid, that was repealed about a year ago, and this year, for the first time, funding for that program is subject to discretionary appropriations. In the 2001 bill that was just signed into law, only $52 million was appropriated for the Medicare education program.

The other area of importance, I think, in reaching beneficiaries is a concerted outreach attempt. Many beneficiaries in the most vulnerable financial circumstances are not aware of the protections that are offered through Medicaid, through the QMB and SLMB programs, and particularly in the post-welfare reform, the TANF era of income assistance, many eligibility activities by states have suffered and as a result, participation and enrollment in Medicaid and in QMB/SLMB has suffered accordingly. There are some bright lights there, however, in the sense that on one hand, the Social Security Administration is now participating in a demonstration program in about five of their district offices where they're actually providing assistance for enrollment, Medicaid, SLMB/QMB eligibles, which is a tremendous opportunity, I think, to demonstrate that with more accessible and appropriate assistance in enrollment, we could greatly increase the participation rates.

The Health Care Financing Administration is also established as a goal in the government reform and--Government Results and Reform Act, the so-called GFRA Act, a goal of increasing by 2 percent in each state the eligible, dual eligbles and getting them enrolled in Medicaid so that they can enjoy the protections of that program, and I think, clearly the time has come and passed when we should consider expanding the eligibility limits to QMB/SLMB because of these growing liabilities that those two programs were designed to help protect beneficiaries from.

Lastly, and in closing, I think that the other area that deserves some attention is in the area of the Medigap or supplemental insurance marketplace. I think the time has come to take a look at the benefit design, which is currently prescribed in the law. It's also come, I think the time has come to take a look at trying to stabilize that market to improve the value associated with the products that are offered by private insurance companies in that individual market. And I think one of the steps that we need to consider is how we can create either some re-insurance or some pooling so that, in fact, stop-loss protection could be offered through the Medigap program, which is not a feature that's currently available. And I think we

need to make sure that the protections in the Medigap market that are in the law now are being vigorously and effectively enforced by state insurance departments who have the primary responsibility for overseeing that marketplace. So I think those are some changes and some considerations we ought to be making in order to extend the kind of protection that beneficiaries are going to need as they experience the growth that this paper so dramatically demonstrates. Thank you very much. John?

MR. JOHN ROTHER: Good afternoon. I'm here, fresh off the holiday, where I spent a lot of time with my grandson who's now in Kindergarten, and he reminded me that there's only two basic questions in life - "oh yeah", and "so what?" And so this is a terrific paper on the "oh yeah?" part, and I'm going to try to deal with the "so what?" I do want to thank the Urban Institute for convening this and especially Marilyn and Stephanie for producing an excellent, timely, and very useful paper.

As far as what's new in this paper from my point of view, it's two things. One, for the first time, we're looking at different groups within the Medicare population, which is absolutely crucial. It doesn't mean anything anymore to talk about averages when you talk about Medicare, because there's so many different people and situations, insurance, types of coverage, so it's very important that we always try to do what this paper does do, and that is take a look at the differences within a population and the distribution. And secondly, we're looking at not just the situation today, but the situation in 25 years, and as Stephanie says, that means everybody who's 40 or above. We're looking at our future health insurance program and it's not a pretty picture.

So what's Congress going to do? What's the political ramification of this report and the facts that it points to? Well first of all, I think there is a commitment on the part of almost every elected member of Congress to try to enact an adequate Medicare prescription drug benefit in the coming Congress, and that's a major part of the problem, but it's not the whole problem. But along with the effort to enact a prescription drug benefit, I think we're going to see related efforts to look at Medicare itself and think about related structural reforms, and part of that debate will certainly be a look at the current cost-sharing arrangements within Medicare. There is a rationale for some cost-sharing to have people make more appropriate use of health care services, but as these figures indicate, we've gotten way beyond that. There's no policy rationale for the kind of economic burden that we're talking about here and no other health insurance policy, certainly no health insurance policy that anyone in this room has, contemplates anything close to the kind of out-of-pocket cost burden that Medicare now permits for those without any other supplemental coverage. So we are

going to be looking at this sooner rather than later in the Congress, I think in the context of both a drug benefit and also an effort to address the whole cost-sharing structure of the program. It is an opportunity, in that respect, to rationalize what's now a not-very-rational benefit package and I certainly want to second Mike's call for a stop-loss or a major medical cap as part of that, so that we don't have the absurd projection that we have here. It's not absurd in terms of economic models, but from a policy point of view, having low-income older women looking at spending three-quarters of their total income in out-of-pocket costs, Medicare would have to be judged a failure as a program if that were allowed to continue as a trend.

I think the bigger point here that this report so vividly demonstrates is that to the extent that in the past we've thought about the solution to rising health care costs as shifting those costs to consumers or to the beneficiaries, we're about at the end of that road. There's not much room left here to shift additional costs. As I indicated, there's room to rationalize, but there's not much room to shift. And with the pressures that the program's facing in terms of growing health-care costs generally and in terms of the projected doubling of the number of people in the program, it's clear that part of the political consequence to this study is that we have to put the revenue question back on the table, because Medicare is going to need more revenue, and all of us who are over 40 today are going to want more revenue for that program in 25 years when we're there.

Now fortunately, we're in a time where the revenue exists and so it's very fortunate to have the kind of surplus projections at the same time that we look at the future of the Medicare program. And so I think that the most immediate consequence of this report is to remind people as we look at how that surplus might be used, that health care claims, not only in Medicare but for the uninsured as well, are going to be a very high priority in the minds of the public as to the allocation of that surplus. It can be done through different mechanisms and there's different ways to structure it, but the basic point is we have the opportunity now, in a fairly timely way, to really make some important decisions about how we're going to meet these challenges on the revenue side, and of course, that doesn't obviate the need for doing whatever we can on the design of the program and different ways to structure cost-sharing. But I think that if I had to kind of get to the bottom line politically here, number one, it would be looking not just at averages, but at the distributional impact of different groups within the program. That leads to clear need to put in place some new benefit limitations, a stop-loss, clear need to enact a Medicare drug benefit, clear need to rationalize the current cost-sharing arrangements. I think there is, for example, a difference between out-of-pocket costs that go to premiums which are predictable and which most people simply net out of their income, as

opposed to out-of-pocket costs at the point of service, which can, if they get excessive, literally be a life-or-death matter.

So I think, again, I'd close with saying thank you to the Urban Institute and to Marilyn and Stephanie, a very timely paper and one that is going to have real consequences in the upcoming Congressional session.

DR. MOON: Thank you, John, for those kind words. I was also struck by Mike's number. I remember a few years ago when we were talking about consumer education and we were outraged to think that we could try to do it for $5 or $6 per capita, and if my math is right, this is a dollar and a quarter per beneficiary to provide consumer education to a group of folks who tend to be a little confused out there these days about some of what's going on.

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