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MEDICARE REFORM: ISSUES AND IMPLICATIONS FOR RETIREE HEALTH INSURANCE

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EXECUTIVE SUMMARY

The standard Medicare benefit package includes a considerable amount of beneficiary spending. Hospitalizations are covered by Part A and entail a per-admission deductible of over $1,000. Physician services are covered by Part B and entail both a premium of at least $96 per month (for 2008) and a 20 percent coinsurance rate on covered services. Prescription drugs are covered by Part D and entail both a premium averaging about $28 per month and significant cost-sharing, particularly within the so-called "donut hole" gap in coverage. For this reason, it is crucial for future Medicare beneficiaries to be adequately prepared for the high costs of healthcare spending in retirement, especially given the trends of both healthcare spending growth outpacing general inflation and the recent gradual erosion of retiree health benefits. The most likely reforms to Medicare are likely to increase the need for adequate savings even more. Policymakers appear to be reluctant to limit the administered prices for physician services and pharmaceutical drugs in order to lower total spending. Policymakers, on the other hand, appear to be eager to both cut payments to Medicare Advantage plans – thereby decreasing the benefits available to enrollees through these private plans – and impose increased means testing of premiums for Parts B and D of Medicare – thereby increasing the premiums required for higher-income beneficiaries. The demand for retiree health benefits is therefore expected to increase over time.

I. INTRODUCTION

Medicare coverage is complex. Part A of Medicare covers inpatient hospital care and is financed by a Trust Fund from a payroll tax on workers' wages. Part B of Medicare covers physician and outpatient care and is financed by a mix of general revenue from the Treasury and monthly premiums paid by Medicare beneficiaries. Part D of Medicare covers prescription drugs and is also financed by a mix of general tax revenue and monthly premiums. (The premiums for Parts B and D are each set to about 25 percent of total respective spending.) Parts A and B are administered directly through the Centers for Medicare and Medicaid Services (CMS), while Part D is administered indirectly by CMS though private insurers. Enrollment into Part A is automatic upon turning age 65 (if one has accumulated 40 quarters of covered employment), while enrollment into Parts B and D is voluntary, but nearly universal given the relatively large subsidies. Finally, seniors have the option of enrolling instead in private "Medicare Advantage" plans – previously known as Medicare Part C and "Medicare + Choice" – which provide all of the medical services covered by Parts A, B, and (most often) D.

Medicare coverage is, however, incomplete. For Part A, beneficiaries pay a $1,024 deductible (for 2008) for each hospitalization, with an additional $256 per day for days 61 through 90 and an additional $512 per day for stays longer 90 days.[1] For Part B, beneficiaries pay a small annual deductible of $135 (for 2008) and a coinsurance rate of 20 percent for all physician and outpatient services, in addition to a monthly premium of $96.40. For Part D, beneficiaries pay a small annual deductible of $275 (for 2008), and then varying levels of coinsurance based on total prescription drug spending for the year, in addition to a monthly premium averaging $28. The so-called "donut hole" in coverage for the standard Part D drug benefit has been both well publicized and much maligned. For total drug spending between $2,510 and $5,726 in 2008, beneficiaries pay the full cost of their drugs – yielding total out of pocket spending of $4,050 for someone with $5,726 in total drug costs. Private insurers do offer alternative stand-alone Part D plans with lower levels of cost sharing and coverage in this gap, but the premiums for such plans are significantly higher.

As a result, Medicare beneficiaries overwhelmingly have some form of supplemental coverage – either from public Medicaid programs, former employers, or private insurers. Medicare beneficiaries near poverty may be eligible for state Medicaid coverage. These "dually eligible" beneficiaries have Medicaid cover the cost-sharing requirements for Parts A and B described above. A federal low income subsidy is similarly available for Part D drug coverage. (State Medicaid programs covered prescription drugs prior to the introduction of Part D in 2006, and are now required to send money to the federal government through so-called "clawback" payments.)

For non-poor Medicare beneficiaries, many have retiree health benefits from a former employer to cover these cost-sharing requirements. (Retiree health benefits are considered

[1] For those with only 30 to 39 quarters of covered employment, Part A can be purchased for a premium $233 per month, and for those with less than 30 quarters of covered employment. Part A can be purchased for $423 per month.

in more detail in Section II.) For non-poor Medicare beneficiaries without retiree health benefits, supplemental coverage can be obtained in one of two ways. One way is to opt out of Parts A, B, and D and enroll in a private Medicare Advantage plan; most, though not all, Medicare Advantage Plans offer more generous benefits than the standard benefits from Parts A, B, and D. The other way is to purchase a so-called "Medigap" policy in the private market to cover the cost-sharing requirement for Parts A and B; these plans are standardized by CMS and subject to varying degrees of state regulation.

Figure 1 shows the percentage of the non-institutionalized Medicare beneficiaries with public Medicaid supplemental coverage, employer-sponsored coverage, private Medicare Advantage plans, Medigap coverage, and no supplemental coverage for years 1999 and 2004. The most common source of supplemental coverage is employer-sponsored plans, at 33 percent in 1999 and 32 percent in 2004; the second most common source of supplemental coverage is Medigap policies, at 27 percent in 1999 and 29 percent in 2004. While enrollment in private Medicare Advantage plans decreased from 18 percent in 1999 to 15 percent in 2004, enrollment has increased considerably since 2004 (due to federal policy changes discussed below), and is thought to be as high as 20 percent in 2008 (although no comparable data for the other sources of coverage is available for later than 2004).

FIGURE 1
SOURCES OF SUPPLEMENTAL COVERAGE FOR MEDICARE BENEFICIARIES

Source: Estimates for 1999 are adapted from Figure 1-5 of the Medicare Payment Advisory Committee's June 2002 "Report to Congress: Assessing Medicare Benefits", and estimates for 2004 are adapted from Chart 6-1 of Medicare Payment Advisory Committee's June 2007 "A Data Book: Healthcare Spending and the Medicare Program". The estimates in these reports are from the 1999 and 2004 Medicare Current Beneficiary Survey's Cost and Use files.

Notes: The Medicaid classification here encompasses both "Medicaid" and "other public sector" for simplicity. In 1999, the private managed care plans were actually called "Medicare + Choice (M+C)" plans rather than "Medicare Advantage" plans.

II. TRENDS IN MEDICARE SPENDING AND COVERAGE

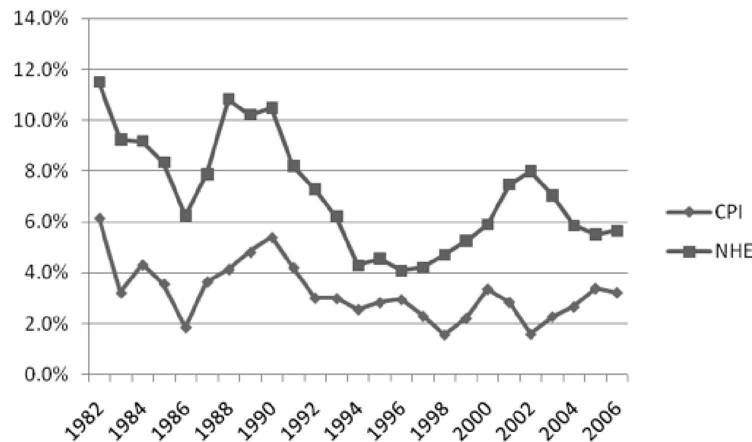
Two general trends suggest that future Medicare beneficiaries should be vigilant in ensuring that they generate adequate savings during their working years to cover all their retirement healthcare costs.[2] The first trend is growth in healthcare spending that exceeds the general rate of inflation. This implies that future Medicare beneficiaries will devote a larger share of their retirement income to healthcare costs than current Medicare beneficiaries devote now. The second trend is a gradual erosion of retiree health benefits. This implies that relatively more future Medicare beneficiaries will require additional savings to cover the cost-sharing requirements of Medicare services, unless this trend reverses. (Section III of this paper examines a few of the more likely potential reforms to Medicare under consideration by policymakers and the resulting implications of these reforms for future Medicare beneficiaries.)

II.A. Healthcare Cost Growth

Figure 2 shows the annual growth rates in the National Health Expenditures and the Consumer Price Index for years 1982 to 2006. Over the past 25 years, healthcare spending has increased an average 7.1 percent per year, while general price inflation in the economy overall has increased an average 3.1 percent per year. (The temporary decrease in the growth in healthcare spending observed during the mid 1990s was caused by a shift towards, and then a subsequent shift away from, more restrictive managed care practices in HMOs.) Projecting healthcare costs into the future is fraught with uncertainty, but most analysts generally expect similar growth rates for healthcare spending in the near future. Consider, for example, the effect this has on premium contributions for Medicare. As noted above, the monthly premium for Part B in 2008 is about $96 and the average premium for Part D is expected to be about $28. Simply applying these average growth rates for medical and general price inflation to this $124 total monthly premium yields an amount for retirees in ten years that is equivalent to $179 today and an amount for retirees in twenty years that is equivalent to $260 today.

[2] For more detail regarding retiree health benefits for those prior to Medicare eligibility, see Marilyn Moon, 2007, "Early Retiree Health Insurance Issues," TIAA-CREF Institute's Trends and Issues Series.

FIGURE 2
ANNUAL GROWTH RATE IN NATIONAL HEALTH EXPENDITURES (NHE) AND THE CONSUMER PRICE INDEX (CPI) OVER THE LAST 25 YEARS



Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

The CMS actuaries, of course, do a much more careful job than this simple extrapolation for projecting Medicare spending further into the future. Total Medicare spending was 3.1 percent of gross domestic product (GDP) in 2006 and is projected by them to be 11.3 percent of GDP in 2081.[3] (In comparison, Social Security spending was 4.3 percent of GDP in 2006 and is projected to be 6.3 percent of GDP in 2081.[4]) The projected 75 year deficit for the Part A Trust Fund is 3.55 percent of Medicare covered payroll, implying that a more than doubling of the combined Medicare payroll tax from 2.90 percent to 6.45 percent would be necessary to ensure solvency over this time period. (In comparison, the projected 75 year deficit for Social Security is 1.95 percent of Social Security covered payroll, implying an increase in that payroll tax from 12.40 percent to about 14.35 percent would be necessary for solvency.) Because a little less than half of total federal Medicare spending is financed by the payroll tax, there is an analogous expected impact on general tax revenues that is not as transparent as the Part A Trust Fund.

The Congressional Budget Office (CBO) is even more pessimistic about the long-term solvency of Medicare than the CMS actuaries. CBO recently projected total federal spending on Medicare equal to about 19 percent of GDP in 75 years (in contrast to 11.3 percent of GDP from CMS).[5] The discrepancy between these projections is primarily caused by differing assumptions for the growth in Medicare costs per beneficiary between 25 and 75 years from now. (The implications of these actuarial projections for policymakers considering reform are considered in Section III below.)

[3] Medicare Board of Trustees, 2007, The 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Federal Medical Supplementary Medical Insurance Trust Funds. Washington, D.C.
[4] Social Security Board of Trustees, 2007, The 2007 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds. Washington, D.C.
[5] Congressional Budget Office, 2007, "The Long-Term Outlook for Health Care Spending."

Almost all evidence indicates that the bulk of this increased medical spending over time is due to the advent of costly new medical technologies. Economists argue that increases in medical spending should not be viewed as problematic if they are linked to improvements in health with an even higher associated value. For instance, David Cutler (2007) estimates that the increased costs of technological improvements in revascularization following a heart attack are about $40,000 and that the increased benefits are an over one year increase in life expectancy – generally considered to be valued at about $100,000 per year.[6]

Of course, costly new medical treatments vary in their cost-effectiveness, so some other recent advances in medical treatments would likely be deemed socially wasteful instead. Some treatments are also cost-effective for only some subset of patients. The challenge facing private insurers and government regulators is to distinguish the high-value care from the low-value care. As such, Peter Orszag, Director of the CBO, has been a strong proponent of establishing a center to study the "comparative effectiveness" of different treatments. While there is certainly some waste that exists in the U.S. healthcare system, the general consensus from this body of work is that the advent of new technologies over time has improved our well-being sufficiently to justify the extra spending. The resulting implication for future Medicare beneficiaries should be a societal willingness, albeit a cautious one, to accommodate greater medical spending because of the associated improvements in life expectancy and quality of life.

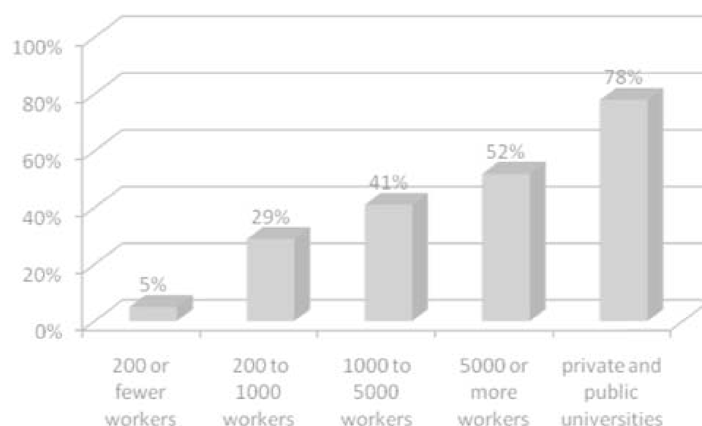
II.B. Changes in Retiree Health Benefits

As shown in Figure 3, larger employers are generally more likely to offer health insurance benefits to their workers in retirement. Retiree health benefits are currently offered to active workers at about 5 percent of firms with less than 200 workers, 29 percent of firms with between 200 and 1000 workers, 41 percent of firms with between 1000 and 5000 workers, and 52 percent of firms with more than 5000 workers. About 78 percent of private and public universities currently offer retiree health benefits to faculty. Among private-sector firms with more than 1000 workers who offer retiree health benefits, 85 percent provide benefits to retirees both under and over age 65, 14 percent provide benefits only to retirees under age 65, and 1 percent provide benefits only to retirees over age 65.[7] (This Policy Brief focuses on supplemental coverage for the Medicare-eligible population over age 65, but much of the discussion is relevant to health benefits for retirees under age 65, as well.)

[6] David Cutler, 2007, "The Lifetime Costs and Benefits of Medical Technology," *Journal of Health Economics* 26.6: 1081-1100.

[7] Kaiser Family Foundation and Hewitt Associate's 2006 Survey on Retiree Health Benefits.

FIGURE 3
PERCENT OF EMPLOYERS OFFERING RETIREE HEALTH BENEFITS, 2007



Source: Estimates for employers by the number of workers are from the Kaiser Family Foundation and Health Research and Educational Trust's 2007 Annual Survey of Employer Health Benefits. The estimate for private and public universities is from Valerie Martin Conley, 2007, "Survey of Changes in Faculty recruitment Policies 2007," TIAA-CREF Institute's Research Summaries/Surveys Series.

Notes: These estimates may not be directly comparable because they are from two separate survey designs.

However, many employers have scaled back their retiree health benefits over the past decade or so. About 33 percent of firms with more than 200 workers offered retiree health benefits to active workers in 2007, compared to about 66 percent of firms with more than 200 workers in 1998.[8] About 55 percent of private and public universities offering retiree benefits reduced the level of those benefits for either active or retired faculty members between 2000 and 2007.[9] The introduction of the Medicare Part D benefit in 2006 included subsidies towards employment-based health benefits for retirees – paying 23 percent of retiree's drug costs between $275 and $5,600, if the drug coverage in the retiree health plan is at least as generous as the basic Part D benefit. The rationale for this Retiree Drug Subsidy component to Part D was to prevent employers from scaling back their retiree health benefits, but it is too early to know how employers have actually responded in a systematic way.

This erosion of retiree health coverage over time seems to most observers to be a simple, and intuitive, response by employers to the high growth in medical spending noted above (and shown in Figure 1). However, from the following different perspective, this reduction in benefits may actually seem somewhat illogical. The reason employers offer benefits, such as health insurance and retirement benefits, in the first place, is to presumably attract high-quality workers who view these benefits as components of their total compensation

[8] Kaiser Family Foundation and Health Research and Educational Trust's 2007 Annual Survey of Employer Health Benefits.

[9] Valerie Martin Conley, 2007, "Survey of Changes in Faculty recruitment Policies 2007," TIAA-CREF Institute's Research Summaries/Surveys Series.

package – especially when those benefits are exempt from payroll and income taxation. For this reason, we should generally expect a one-to-one tradeoff between cash wages and benefits, and, in addition, expect an incentive to have relatively more generous benefits, all else equal, at the expense of relative lower wages, when those benefits are shielded from taxes – especially among higher-income workers with higher marginal tax rates.[10] Because retiree health benefits are exempt from income and payroll taxes and because there is presumably higher employee demand today for retiree health benefits because of the high anticipated growth of healthcare costs in retirement, we might have expected the generosity of retiree health benefits to have increased rather than decreased over the past decade or so.

There are, however, at least two potential complications to this suggestion that retiree health benefits should have actually increased. The first is the extent to which employees and employers have similar expectations for future healthcare cost growth. The above story requires that employees value a future fringe benefit at least as large as the employer does (in terms of the actual cost in providing that fringe benefit), in order for employees to accept a commensurately lower wage – thereby keeping the value of the total compensation package the same. If, however, employers anticipate higher future healthcare cost growth – as may indeed be the case due to employers recent experiences with struggling to contain healthcare costs and due to employees relative insulation to rising healthcare costs – then it may have made sense for employers to have simply stopped offering retiree health benefits because those workers incorrectly perceived those benefits having less value than their "true" cost. Ideally, employers would instead better inform their workers about the true value of retiree health benefits in the future rather than simply dropping retiree coverage, but this may be quite difficult to achieve in practice.

The second complication to the above suggestion that the recent erosion of retiree health benefits was somewhat illogical is the very real possibility of some employers eventually reneging on the benefits "promised" to their workers. Unless there is a legal contract specifying otherwise, employers are able to impose reductions in the benefits of retiree health coverage over time (e.g., higher premium contributions, higher cost sharing, and lower caps on lifetime benefits). Moreover, the possibility of a company going bankrupt implies the threat of losing one's retiree health benefits altogether; retiree health benefits do not have the same amount of ERISA protection as retiree pension benefits. While recent changes to FASB require that retiree health benefits now appear on corporate balance sheets, this may actually lead to employers changing their perception of providing benefits for relatively older retirees. Because there should be strong demand for supplemental coverage for Medicare and because that demand is likely increasing over time due to the growth in healthcare spending, many workers may increasingly prefer the certainty of planning for their own healthcare spending in retirement to the uncertainty of relying on an employer to cover that spending. The recent willingness of the United Auto Workers to enter into a Voluntary Employees' Benefits Association (VEBA) with Ford, General Motors, and Chrysler for a pre-funded amount that many analysts consider to be

[10] A progressive marginal income tax rate schedule therefore results in a regressive subsidy towards employment-based health insurance.

significantly smaller than the value of the projected healthcare obligation is consistent with this suggestion that there is concern among current workers about the availability of future "promised" benefits.

In the end, if the increase in the underlying demand for retiree health benefits was less than any increased discrepancy in expected healthcare cost growth and increased uncertainty about fulfilling the "promises" made, then the reduction in employer offer rates in recent years may have actually been rational. But actually knowing the relative magnitude of these effects is difficult.

III. PROSPECTS FOR MEDICARE REFORM

On the surface, increasing the solvency of the federal Medicare program is quite simple. Just as an individual losing weight simply requires some combination of eating fewer calories and exercising more, increasing the financial outlook of the Medicare program simply requires some combination of raising taxes – in this case, both the payroll tax for Part A and general tax revenues for Parts B and D – and decreasing benefits – which could take the form of either reducing services covered by Medicare, increasing deductibles and/or coinsurance for covered services, or increasing premium contributions for the same level of covered services.

Politically, however, increasing the solvency of Medicare is very difficult, as is probably no surprise (much like an individual actually losing weight requires tremendous will power). The immediate problem, of course, is the political difficulty of actually raising taxes or cutting benefits. Raising tax rates can have adverse effects on the economy or diverting existing tax revenue towards Medicare could reduce funding for other public programs such as education, and senior citizens will be vehemently opposed to reductions in benefits (even if the phrase "slowing the growth in spending" is used to wordsmith the true nature of these changes). The not-so-immediate problem, though, is the difficulty of identifying concrete ways to actually decrease Medicare spending, even if the political will to do so existed. For instance, the different options to "fix" Social Security are relatively well-known: raise the payroll tax rate, raise the cap on wages subject to the Social Security tax, and/or index benefits to the growth in inflation rather than wages (perhaps only for higher-wage retirees). There is, in contrast, no straightforward way to simply lower Medicare spending per beneficiary by decree, because spending is a complicated mixture of provider reimbursement and beneficiary utilization. If we really knew how to reduce healthcare spending, we probably would have done so years ago. As a result, many of the likely reforms involve increased risk sharing by beneficiaries, as opposed to reducing overall utilization in the system.

The remainder of this Policy Brief focuses on the rationale for, and likely effects of, three broad types of Medicare reform: reducing payments to medical providers, reducing payments to private Medicare Advantage plans, and expanding the so-called "means testing" of benefits. Another option would be to increase the eligibility age over time to age 67 to match that for Social Security among those both in 1960 or later. While this certainly

seems like a step in the right direction, increasing the eligibility age for Medicare will have a smaller effect on reducing benefits than it did for Social Security. This is because the younger Medicare beneficiaries are, on average, in much better health and thus have lower levels of medical spending; Social Security benefits, in contrast, are more uniform by age. Although people ages 65 and 66 represent about 9 percent of Medicare beneficiaries, they only account for about 4 percent of total Medicare spending.[11] So, raising the eligibility age to reduce the number of those eligible by about 9 percent would instead only reduce Medicare spending by about 4 percent. While important, a 4 percent reduction in benefits is much smaller than the projected 51 percent reduction in benefits that the Medicare actuaries project to achieve solvency over 75 years.[12] In addition, raising the eligibility age might also exacerbate the problem of the near-elderly uninsured – and increase considerably the cost of providing retiree health benefits to those not yet eligible for Medicare. Other promising reforms, not discussed here include the increased use of disease management for those with chronic health conditions, implementation of electronic medical records and other information technology, and efforts to reduce geographic variation in spending.

III.A. Payments to Providers

One broad type of potential reform to Medicare is to alter the reimbursement for hospitals, physicians, and prescription drugs. Because of the way hospital care is financed through Part A of Medicare – namely, a payroll tax on current workers and a set deductible per hospitalization plus co-payments for longer stays – potential reforms to hospital reimbursement from Medicare are likely to have relatively less of an effect on healthcare spending by future Medicare beneficiaries.

Potential reforms to Medicare reimbursement for physician, in contrast, will have sizable effects on beneficiary spending. Payments to physicians from CMS are pre-determined by a set fee schedule which takes account of variation across specialties in labor, practice expense, and malpractice premiums. Each year, there is an annual "across the board" update to the fee schedule, which has been determined by a so-called "Sustainable Growth Rate" (SGR) mechanism since 1998. (Few outside of D.C. policy "wonks" and physicians are familiar with the SGR.) The SGR seeks to control the growth of Medicare Part B spending by determining a target level of spending, based largely on the "input prices" physician practices face and on overall GDP. This annual "across the board" update in fees is chosen to attempt to meet that target.

The 2007 update was scheduled to be a negative 5.1 percent relative to 2006's level (i.e., projected 2007 spending was well over 2007's target), but Congress (as it had in several prior years) passed a last-minute bill in December 2006 to override the SGR's scheduled cut by

[11] Council of Economic Advisors, 2007, "The Fiscal Challenges Facing Medicare," *Economic Report of the President*. Washington D.C.

[12] Medicare Board of Trustees, 2007, The 2007 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance Federal Medical Supplementary Medical Insurance Trust Funds.* Washington, D.C.

instead allowing nominal fees to remain the same for 2007. Similarly, the 2008 update was scheduled to be a negative 10.1 percent relative to 2007's level, but Congress again acted to override this cut, although for only the first six months of 2008. The issue will therefore arise again in the summer of 2008. However, changes to the fees paid to physicians do not generally have a one-to-one effect on changing Medicare Part B spending for physicians, because physicians are thought to respond to price cuts by increasing the quantity and intensity of services supplied in order to mitigate the effect that the reduction in price has on total revenue; CBO has historically assumed a second-order "volume offset" in spending of 50 percent to counter the first-order effect of physician fees on spending.

What do these issues surrounding the annual physician fee update mean for Medicare beneficiaries and retiree health benefits? Because the Part B premium contribution for beneficiaries is defined to be 25 percent of projected total Part B spending and because the coinsurance rate for physician services is 20 percent of the fee, relatively higher physician fees (resulting from repeatedly overriding the SGR) mean relatively higher spending by beneficiaries (even after adjusting for a "volume offset"). Congressional fixes to override the SGR-defined update result in higher premiums and higher cost-sharing, which in turn necessitate higher levels of beneficiary savings for retirement. For Medicare beneficiaries with employer-sponsored retiree health benefits, their former employers will instead be the ones adversely affected by the higher 20 percent coinsurance payments that result from increasing physician fees.

However, not overriding the SGR-defined update and allowing the scheduled cuts to Medicare's physician fees to occur may also potentially reduce beneficiaries' access to physician care. As noted above, reducing physician fees lowers beneficiary premium contributions and cost-sharing (and may actually increase the quantity of services provided from participating physicians if a "volume offset" occurs). However, reducing physician fees far enough has the potential to decrease the number of physicians that actually participate in the Medicare program altogether. Each year, the American Medical Association warns policymakers and Medicare beneficiaries that the scheduled cuts in fees would probably cause many doctors to stop seeing Medicare patients which could, in turn, result in delays in obtaining needed care or reductions in the quality of care. Despite these warnings, the number of physicians accepting Medicare patients has remained relatively constant in recent years though: 68.9 percent of physicians reported accepting all new Medicare patients (with an additional 12.0 percent accepting most new patients and 9.4 percent accepting some new patients) in 1996, compared to 69.7 percent accepting all new Medicare patients (with an additional 12.7 percent and 10.0 percent for most new and some new patients, respectively) in 1996.[13] However, the scheduled negative 10.1 percent decrease in fees is twice as large as any previous fee update under consideration, so a tipping point could be approaching.

A similar story exists for pharmaceutical drug prices faced by Medicare beneficiaries. Privately-administered Part D prescription drug plans were added to Medicare in 2006

[13] 1996-1997 and 2003 Community Tracking Study's Physician Surveys.

(increasing the unfunded liabilities for the federal government towards Medicare significantly). The legislation enacting Part D, the Medicare Modernization Act of 2003, specifically included a "noninterference" clause, stipulating that pharmaceutical prices would be determined solely by negotiations in a competitive marketplace between the private Part D plans and pharmaceutical companies – rather than by prices administered directly by CMS.

As with reforms to physician fees, there is a direct relationship between reforms to drug prices, Part D premium contributions and cost-sharing for drugs, and access to care. If drug prices could be lowered by striking the "noninterference" clause, then beneficiary spending would clearly decrease because of the reduction in drug prices. Retiree health plans receiving the Retiree Drug Subsidy from CMS (described above) would also benefit from any reductions in drug prices. However, the expected results from allowing CMS to negotiate drug prices are controversial. The private Part D plans negotiate discounts from the drug companies by their ability to pick only one or two particular drugs within a therapeutic class to appear on its "formulary," or list of covered drugs. Without granting CMS the ability to restrict the coverage of certain drugs, the savings from striking the "noninterference" clause would probably be negligible – as CBO contended in both 2004 and 2007.[14] Any new legislation which does grant CMS with the ability to restrict the coverage of certain drugs or impose price ceilings for drugs could indeed result in lower drug prices which would in turn, decrease spending by Medicare beneficiaries. But the short-term reductions in access to certain drugs – achieved by introducing a formulary – would presumably be quite unpopular among beneficiaries. In addition to the limitations on short-term access to care for current Medicare beneficiaries, there would also likely be long-term reductions in access to care. Because the expected profits from pharmaceutical drug sales in the future are necessary to stimulate the research and development of new drugs in the present, it is quite likely that fewer beneficial drugs would be available to future Medicare beneficiaries.[15]

III.B. Payments to Medicare Advantage Plans

As noted above, Medicare beneficiaries have the option of enrolling in a private health insurance plan to receive Parts A, B, and (in many cases) D services. The different types of these private Medicare Advantage plans include HMOs, Local and Regional PPOs, Private Fee-For-Service, Medical Savings Account Plans, and Special Needs Plans. In many rural areas of the U.S., only Private Fee-For-Service Plans are available. The general tradeoff that beneficiaries face upon enrolling in a Medicare Advantage plan is a reduction in cost-sharing for medical services (e.g., the high deductible for hospitalizations in "traditional" Medicare) versus an increase in the "managed care" restrictions (e.g., not covering certain medical procedures, limited access to only certain physicians identified in a plan directory). Enrolling in a Medicare Advantage plan is therefore only really appealing to those without pre-existing retiree health benefits; the retiree health plan covers the cost-sharing for those

[14] Letter from CBO Director, Douglas Holtz-Eakin, to Senate Majority Leader William H. Frist, on January 23, 2004. Letter from CBO Acting Director, Donald B. Marron, to Committee on Energy and Commerce Chairman, John D. Dingell, on January 10, 2007.

[15] Carmelo Giaccotto, Rexford Santerre, and John Vernon, 2005, "Drug Prices and Research and Development Investment Behavior in the Pharmaceutical Industry," *Journal of Law and Economics* 1: 195-214.

in the "traditional" Medicare program (as a "supplemental" source of coverage), so there would be little to gain from opting for the comprehensive private Medicare Advantage plan. As a result, reforms to Medicare Advantage do not really have a direct effect on retiree health coverage, but there is an important indirect effect: any future contractions (expansions) to the Medicare Advantage program should increase (decrease) the demand for retiree health insurance benefits.

The payment that a Medicare Advantage plan receives from CMS is based on the relationship between the bid it submits to CMS and the "benchmark" rate administratively defined for that county, as established by the 2003 Medicare Modernization Act. The county-level benchmark rate is the greater of the county-level expenditures in the traditional fee-for-service Medicare program, a minimum update over the previous year's payment rate, and a set of "floors" for large urban areas and small rural areas. A plan receives its bid plus 75 percent of the difference between the benchmark rate and its bid. In return, the plan has to provide additional benefits to enrollees equal in value to this 75 percent difference between the benchmark rate and its bid. If the plan submits a bid that is higher than the benchmark rate, the payment from CMS equals the benchmark rate, and an additional enrollee premium equal to the difference between the bid and the benchmark rate is required.

As a result, the payments to Medicare Advantage plans are significantly higher than Medicare's expenditures in the traditional fee-for-service program. (Medicare's fee-for-service expenditures here are the benefits provided by the Medicare program and do not include the payments from retiree health plans or payments make out-of-pocket by beneficiaries.) The Medicare Payment Advisory Commission (MedPAC), an independent federal body established to advise Congress, estimates that these payments are an average 12 percent higher than expenditures in the traditional program.[16] Some incorrectly suggest that this differential between payments to private plans and fee-for-service expenditures reflects 12 percent higher reimbursements to private plans for equivalent benefits. As noted above, each Medicare Advantage plan is required to return 75 percent of the difference between its bid and the county-level benchmark rate in additional benefits to the enrollee. Therefore, some of this differential in costs reflects additional benefits (e.g., lower cost-sharing, additional services such as eyeglasses and hearing aids) while some of this differential reflects higher payments for comparable benefits (i.e., extra profit margins for the private plans). Although no rigorous study decomposing this cost differential exists, a synthesis of some published statistics suggests that about 7 percentage points of this 12 percent difference does reflect additional benefits.[17]

This 12 percent differential for Medicare Advantage plans has become a popular target for

[16] Medicare Payment Advisory Committee's (MedPAC) "March 2007 Report to the Congress".

[17] Page 19 of the CMS report "Medicare Advantage in 2007" indicates that "if one compares comparable benefits (i.e., bids to Original Medicare FFS costs) and does not reduce Original Medicare FFS costs for IME, the differential is reduced from 12 percent to 2.8 percent." The Commonwealth Fund report, "The Cost of Privatization: Extra Payments to Medicare Advantage Plans – Updated and Revised," written by Brian Biles et al. indicates that Indirect Medical Education (IME) represents is about 2.3 percent of the 12 percent differential; see footnote #12 on page 7. This implies extra benefits equal to 6.9 percent (12.0 – 2.8 – 2.3).

Congressional Democrats – especially with "pay go" rules in effect stipulating that spending increases be offset by either spending cuts or tax increases. For instance, CBO estimates that a proposal to reduce Medicare Advantage payment rates to equal county-level fee-for-service expenditures, effective January 2008, would save $65 billion over five years and $160 billion over ten years.[18] An earlier House version of the bill to reauthorize the State Children's Health Insurance Program (SCHIP) included cuts to Medicare Advantage plans to fund SCHIP and "fix" the Part B SGR-related physician update. The subsequent version of the Senate-House SCHIP reauthorization bill (which has been shelved indefinitely, presumably until the arrival of a new President in 2009) stripped the Medicare provisions and instead uses an increase in the cigarette tax to "pay for" SCHIP expansions.

What would cuts to Medicare Advantage mean for Medicare beneficiaries and retiree health plans? Adam Atherly and Kenneth Thorpe (2007) estimate, for example, that setting Medicare Advantage benchmarks equal to fee-for-service expenditures would result in almost one-third of those currently enrolled in the private Medicare Advantage plans to return to the traditional Medicare program.[19] Because enrollees of Medicare Advantage plans are disproportionately low-income and minorities, the NAACP and League of United Latin American Citizens were strong opponents of the cuts to Medicare Advantage plans in the earlier House version of the SCHIP bill. While there is merit to relating benefits received (or premiums paid) in public programs to income, subsidizing Medicare Advantage plans in this manner (in which both higher-income beneficiaries and the shareholders of these private plans also receive benefits) appears to be a poorly-targeted transfer of resources towards lower-income people. Direct subsidies would presumably be a better-targeted transfer of resources.

Despite this opposition, cuts to Medicare Advantage plans do appear inevitable in the future. Because of a narrowing of the gap between the plan bids and the CMS-administered "benchmark" rates that will result from cuts to the Medicare Advantage program, the private plans will likely reduce the additional benefits they provide. This will, in turn, result in decreased enrollment in these plans. For those who remain enrolled, out-of-pocket spending on medical care will increase due to a reduction in Medicare Advantage benefits. For Medicare beneficiaries who opt out of their Medicare Advantage plans, out-of-pocket spending on medical care will likely increase, as well, due to the higher cost-sharing in the "traditional" Medicare program. As a result, the demand for supplemental insurance – both retiree health benefits and private Medigap plans – will likely increase. For current workers planning ahead for retirement who are employed at smaller firms (and relatively much less likely to offer retiree health benefits), the need for adequate savings for medical care in retirement should intensify. For current workers who are employed at larger firms generally more likely to offer retiree health benefits, the likely cuts to Medicare Advantage should increase the attractiveness of receiving these retiree health benefits. Some

[18] Congressional Budget Office's February 2007 Budget Options, See Option 570-2 on page 167.

[19] Adam Atherly and Kenneth Thorpe, 2007, "The Impact of Reductions in Medicare Advantage Funding on Beneficiaries," Report prepared for the Blue Cross and Blue Shield Association.

employers may rightly anticipate this increase in employee demand and increase their offerings of retiree health benefits. Because Medicare Advantage enrollees are generally healthier than other Medicare beneficiaries, there should not be adverse effects on the employer's retiree health risk pool.

III.C. Means Testing in Medicare

Starting in 2007, premium contributions towards Part B became larger for about 5 percent of the highest-income Medicare beneficiaries – also as a result of the 2003 Medicare Modernization Act. In 2008, for single beneficiaries with annual incomes over $82,000 and couples with annual incomes over $164,000, the standard monthly premium of $96.40 will increase to between $122.20 and $238.40 per month. (The $238.40 monthly premium applies to singles with annual incomes over $205,000.) These income thresholds are set to increase over time with inflation. In President Bush's 2008 Budget, he proposed higher premium contributions for Part D premiums with the same annual income thresholds. He proposed, however, to not index these thresholds over time, so that more people would eventually face these higher means-tested premiums.

The appeal of means testing is that it is a way of reducing benefits to Medicare beneficiaries without eroding the protection from financial risk provided to lower-income beneficiaries. Thus, means-tested premiums have the potential for improving the financial sustainability of the program yet maintaining the underlying social insurance objectives of the program. From an economic perspective, there is a limit, though, to the extent of having high-income seniors make larger premium contributions in a non-mandatory government program. Increasing premium contributions could significantly reduce enrollment of younger and healthier beneficiaries, driving up the costs for those remaining in the program. From a political perspective, imposing means-testing in a popular public program is seen by many as an attempt to undermine a sense of "solidarity" among Medicare beneficiaries who until last year all received equal benefits. Indeed, support for means testing is concentrated among Republicans, which is ironic because a generic policy change requiring high-income people to pay more would, on the surface, appear to have predominantly Democratic support.

An increase in the amount of means testing of Medicare premiums does appear inevitable, as well. An alternative to means-tested premiums could be income-related cost sharing; Jason Furman (2007) at the Brookings Institution has advocated this change to risk sharing.[20] For instance, the coinsurance rate for physician services could remain at 20 percent for lower-income seniors and rise to 50 percent for higher-income seniors. As noted above, the appeal of means testing, in general, is that it can improve the program's sustainability and maintain its social insurance objective, but means-tested cost sharing may have an additional benefit: The rationale for coinsurance is that it can decrease the utilization of low-value services through beneficiary cost-consciousness. Because higher-income individuals are relatively less price sensitive than lower-income individuals, income-related cost sharing has the potential for limiting low-value care more effectively.

[20] Jason Furman, 2007, "The Promise of Progressive Cost Consciousness in Health-Care Reform," The Brookings Institution Discussion Paper. Washington D.C.

The implication of this potential reform for future higher-income Medicare beneficiaries is that additional savings for healthcare spending on premium contributions and cost-sharing requirement are likely to be needed. Larger amounts of cost-sharing for higher-income individuals would mean that the demand for supplemental retiree health insurance benefits by higher-wage workers will increase. Depending on how the retiree health plans' contracts are specified to cover beneficiary cost-sharing (i.e., whether they cover a fixed amount per visit or they simply cover what Medicare does not cover), income-related cost-sharing might increase the costs of providing retiree health benefits. While means-tested premiums may not have a first-order effect on the demand for retiree health benefits per se, the fact that retiree savings for out-of-pocket spending would be displaced by higher premium contributions to Parts B and D implies that the demand for retiree health benefits to cover these out-of-pocket payments will increase, as well.

IV. DISCUSSION

The bottom line from the current trends and likely reforms examined in this Policy Brief is that household spending on healthcare in retirement is likely to increase considerably for future Medicare beneficiaries. The growth in medical spending is expected to continue to grow at a higher rate than general price inflation for the foreseeable future. Even in the absence of any Medicare reforms, premium contributions and out-out-pocket spending will consume a larger and larger portion of income for future Medicare beneficiaries. Moreover, the most probable Medicare reforms discussed here will likely increase the fraction of total healthcare spending incurred by Medicare beneficiaries – particularly for those with higher incomes. This will increase the amount of spending on healthcare by Medicare beneficiaries even further.

As a result, the demand for retiree health insurance benefits by knowledgeable workers should be higher now than ever. Because retiree health insurance coverage is a tax-exempt benefit, it makes sense for employees to want to use this mechanism to "save" tax free – by essentially forgoing relatively higher wages in the present for the promise of richer retiree health benefits in the future – to cover their future healthcare spending. A Health Savings Account (HSA) is another potential mechanism for workers to save tax free for future healthcare spending once eligible for Medicare, but there are limitations to its use. It requires people to be enrolled in a high-deductible health plan when making a deposit to the HSA; it does not require people to be enrolled in a high-deductible plan to make a withdrawal. Congress' primary rationale for introducing HSAs was to eliminate the bias towards paying for employment-based premiums with pre-tax dollars versus paying for out-of-pocket payments with after-tax dollars (which was pushing workers towards health plans with very little cost-sharing, which was, in turn, thought to lead to higher total spending). Allowing tax-exempt deposits to be made into HSAs and allowing the deposits to accrue indefinitely if unspent was necessary to eliminate this bias, but it essentially introduced a vehicle for workers to accumulate tax-exempt savings for healthcare spending once enrolled in Medicare. However, this requirement of being enrolled in a high-deductible plan seems to be onerous to many workers – particularly those who are less

healthy and/or more risk averse; currently, only 5 percent of people with employment-based insurance are currently enrolled in HSA-eligible high-deductible plans.[21]

Because of this high underlying demand for retiree health insurance benefits by workers, the recent erosion of employers offering retiree health benefits appears, on the surface, peculiar. We might have expected the number of firms offering retiree health benefits to increase over time rather than decrease to meet this increase in demand. As noted above in Section II.B., however, there may have been logical explanations for this peculiarity: an informational discrepancy between employees and employers surrounding projections in future healthcare spending and a real concern among employees about the ability of employers to follow through on their "promised" benefits. Another more speculative explanation may be that some employers have become increasingly concerned with the uncertainty surrounding fulfilling these commitments. With a defined benefit approach, the employer faces the risk of realizations of medical spending in the future being higher than currently projected – whether through increases in annual healthcare spending or increases in life expectancy. In contrast, with a defined contribution approach, these risks are borne by workers themselves.

Some employers may be willing to accept these risks and continue to offer retiree health benefits with a defined benefit approach. A recent regulation from the Equal Employment Opportunity Commission in December 2007 affirmed that employers could offer retiree health benefits that differ in generosity for retirees under age 65 and retirees over age 65. Some worry that this will open the door for employers to offer less comprehensive benefits for those over age 65, but others suggest that this flexibility will allow employers to continue to offer benefits to both groups (albeit at different levels of generosity) rather than dropping coverage for both altogether because of the risks associated with the Medicare-eligible population. Other employers may still be unwilling to accept these risks and may increasingly begin to offer a pre-funded Voluntary Employees' Benefits Association (VEBA) arrangement with a defined contribution approach. This will essentially allow workers to maintain the benefits of both "forced savings" for future healthcare costs (to combat myopia) and the tax exclusion provided for these savings, yet shield their employers from these uncertainties surrounding future projections of defined retiree health benefits.

[21] Kaiser Family Foundation and Health Research and Educational Trust's 2007 Annual Survey of Employer Health Benefits.