

Chapter 1. Introducing the Issues

Presentation by Kenneth Apfel

Kenneth Apfel: This is the second in our series of conferences on “Big Choices” facing the country. Last year, our conference was on “The Future of Health Insurance for America’s Families.” This year, the topic is “The Future of Health Insurance for Older Americans,” with a specific look at Medicare, a very critical issue for all of us.

First, before starting, I want to thank the LBJ Library and the LBJ Foundation for their support. I also want to thank the Foundation for Insurance Regulatory Studies of Texas as well as the Commonwealth Fund. Support for this activity has been critical to Betty Sue Flowers and me, and we hope to continue these symposia into the future in order to keep a dialogue going about these very big issues facing the country.

We’re here to talk about the future of health insurance for older Americans. But to put the future in context, we need to start off not only with a discussion about the present, but also a little discussion about the past. About a half-dozen times in the 20th century, the United States has tried to take a big action on providing health insurance for Americans. But while this issue has been debated many times in the past century, only once have we produced something really big—and that happened through the leadership of a person whose office was just down the corridor from here after he left the presidency. The creation of Medicare and Medicaid in 1965, under President Johnson, was an enormously big step for this country.

Let’s start by going back to pre-Medicare times. In 1960, poverty rates for older Americans were about 35 percent. That’s over one in three older Americans in 1960 were living in poverty. At least 44 percent of older Americans were uninsured. A large number of older Americans were working still, and one of the reasons they were working was to keep their health insurance. Over half of older Americans no longer in the work force had no health insurance. And the proportion of our older population back then was relatively low, about 9 percent. When we look back to the Johnson era, the significant benefit increases to Social Security had a major impact on poverty rates in the 1960s. The establishment of Medicare in 1965 provided health insurance for almost all older Americans. These are major accomplishments.

Now I’ll provide a brief picture of Medicare for those of you who need to get a snapshot of how the program works so we can frame the debate for the rest of today and tomorrow.

When Medicare was started, it was funded primarily by a payroll tax paid by workers to finance the Medicare benefits for those who had already retired. The tax was about a third of a percentage of payroll. So somebody making \$300 a week would be paying about a dollar a week for the Medicare part of the payroll tax, and employers matched that payment. In addition, an optional Medicare Part B program, which paid primarily for physician services and which almost all older Americans signed up for, is paid for by premiums as well as by general tax revenues. So there are three big sources of funding—

payroll taxes (the direct intergenerational part), premiums paid by older Americans, and general tax revenues paid by all of us.

While the Medicare program is incredibly important, we all need to recognize that from the beginning, it had sizable coverage gaps. Long-term care has never been covered under Medicare, for example. Prescription drugs have not been covered by Medicare—although, frankly, in 1960, prescription drugs were not that big a part of our health care budget, and even many private health care plans did not have a prescription drug benefit. Also, catastrophic coverage was not part of Medicare, nor was most preventive care. So, the benefit package for Medicare, while important, is really a relatively modest level of acute care coverage, compared to most private-sector insurance plans. Because of that, about 85 percent of older Americans have some form of supplemental coverage in the form of Medigap policies, or employer-provided health insurance, or sometimes Medicaid to supplement the Medicare package.

So in 1965, an important program was created, but it had significant gaps and modest coverage. What's happened since then? As the health care system has evolved over time, Medicare tried to catch up with its coverage. For example, as more health care expenses took place out of the hospital, such as in ambulatory surgical centers, Medicare would reimburse for those activities as well. Hospice benefits, which didn't exist back in the 1960s, have been added, as well as expanded home health care and more hospitalization. During that same time, premiums have increased. The premium in 1970 was \$4 a month, and in 2000 was \$45 a month. Other revenues have increased, but so have the number of beneficiaries and the cost of health care.

When you have the number of beneficiaries increasing and you also have health care costs increasing per person, you're going to end up with some very sizeable cost increases, which we've seen in Medicare. Medicare spending has gone up—it is now one of the largest federal budget items. It's about 2.5 percent of our entire economy, and about 13 percent of the federal budget. It is now the third-largest government program behind Social Security and defense.

An important program? Absolutely! Costly? Absolutely, and in my opinion, worth every penny. But to understand Medicare, you have to understand the cost issues as well as the important benefit issues that are out there. And costs have gone up quite substantially.

So how have we tried to deal with these cost increases since 1965? As Figure 1.1 illustrates, there have really been two ways—increasing revenues and containing costs.

Figure 1.1
Past Approaches to Rising Costs of Medicare

| Raise Revenues | Contain Costs |
|---|--|
| 1) Increase payroll tax 2) Remove wage cap on taxable income 3) Raise premiums 4) Tax Social Security benefits 5) More general revenues | 1) Increased regulatory cost controls 2) Encourage market-based initiatives (HMOs, Medicare+Choice) |

A number of steps have been taken to increase revenues so as to provide an adequate financing base for the Medicare system. For example, payroll taxes, which used to be one-third of a percent of payroll, is now about 1.5 percent of payroll—so that’s a substantial increase in the share of payroll taxes that workers have to pay for the Medicare program (matched by their employers).

Secondly, in 1993, the wage cap was taken off the Medicare program so that payroll taxes are paid not only on that first \$80,000 or \$90,000 of income, but on all of it. So the Bill Gateses and the Michael Dells pay 1.5 percent of payroll for their entire wages—not their stock options, but their entire wages.

Third, monthly premiums have increased from about \$4 in 1970 to about \$67 now. Fourth, Social Security benefits were taxed, first in 1983 for monies to be put into the Social Security system, then again in 1993 for those added revenues to be put into the Medicare program. Lastly, since part of Medicare financing comes from general tax revenues, this has increased very substantially over time as Medicare’s overall costs have increased.

On the cost containment side, there has been a two-pronged effort. On the regulatory side, beginning in 1983, Medicare started paying hospitals a fixed amount based on a particular diagnosis to try to help hospitals control their costs, and as an incentive to change their behavior. Similar changes were made for physician reimbursements as well as for home health care and skilled nursing facilities.

A second approach was an attempt to encourage market-based initiatives. HMOs have been part of Medicare for many years, although just a very small part. But starting in 1997, Medicare Plus Choice was enacted to try to create better incentives for individuals to choose private plans. The idea here was for beneficiaries to choose private plans to get better benefits, like prescription drug coverage or other things, and that competition from these plans would create incentives for cost control.

So where has all this taken us from 1960 to the year 2000? First, poverty rates for older Americans are down dramatically from 35 percent to 10 percent. The proportion of the uninsured since 1960 is down even more dramatically from 44 percent to 2 percent. I

think these two changes form the greatest success story for the elderly in 20th-century American domestic policy because they resulted in a dramatic reduction in poverty and near-universal health coverage.

I also want to point out that 10 percent of older Americans are still living in poverty, including about 20 percent of elderly widows, African Americans and Hispanics. And though virtually all older Americans have health insurance, health care is still a major expense for the elderly. There are still real needs out there, but overall this is a profoundly important success story. Health expenses, which consumed about 20 percent of total income back in 1960, still consumed about 20 percent of income in 2000. Seniors' incomes grew considerably during that period of time.

So what can we conclude about Medicare? I think we can conclude that it's one of the most successful programs of the 20th century. It's clearly helped older Americans to gain access to basic health care services. We can also conclude that there are still some continuing gaps in coverage, and they are very real—prescription drugs, in particular.

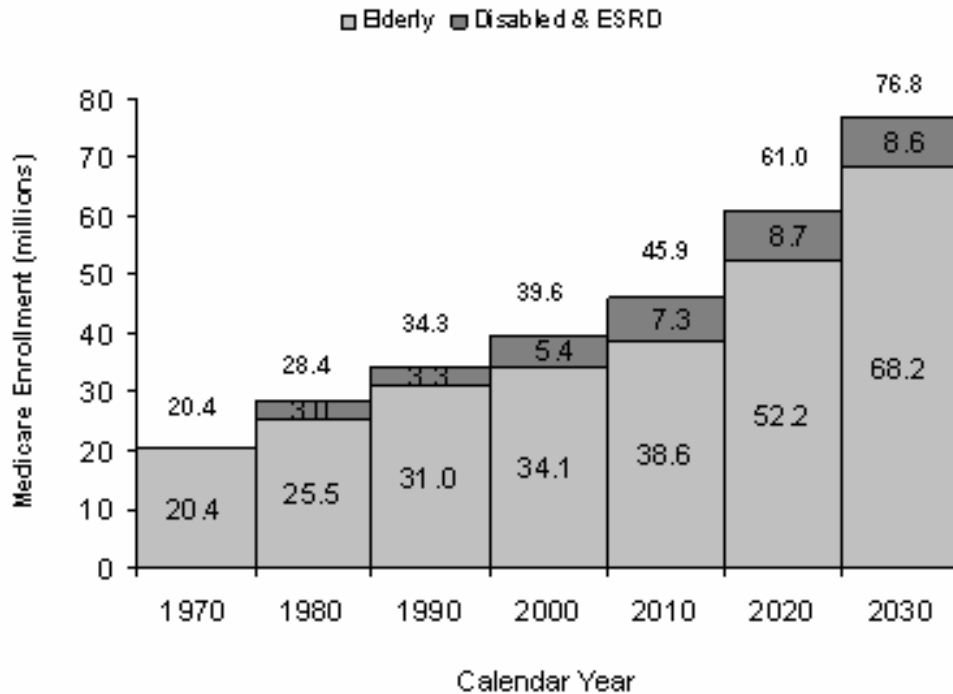
We will focus on prescription drug coverage during this conference. At the end of the Reagan administration, there was an effort to provide prescription drug coverage as part of the Catastrophic Care Act. It was enacted in the last year of the Reagan administration and repealed in the first year of the Bush One administration. While it provided a prescription drug benefit, but it also greatly increased premiums, engendering quite a bit of negative response, so it was repealed. So the notion of creating a prescription drug benefit is not a new issue.

While about three-quarters of older Americans have some kind of prescription drug coverage, only about half have comprehensive prescription drug coverage. About a third of older Americans have prescription drug costs that are only about \$500 or less. But another third have costs that are \$2,000 to \$5,000. So there are a lot of older Americans with very high prescription drug costs, and this is a large unmet need. It's one of the reasons there has been such an effort to try to provide a prescription drug coverage benefit to fill one of the important holes in the Medicare program.

It is clear that the Medicare program has come a long way since 1965. Where are we headed in the future? More specifically, where are we headed on the number of beneficiaries, on costs, on premiums? And what's the outlook for the financing picture of the Medicare program in the years to come?

As Figure 1.2 shows, the number of Medicare beneficiaries is scheduled to double in the next 30 years. It doubled from 1970 to the year 2000, from about 20 million to about 40 million. And it's scheduled to double again by about 2030. But because we won't have the same kind of labor force growth in the next 30 years that we did the last 30 years, we're going to have a growing problem, with real fiscal pressures as my generation moves toward retirement.

Figure 1.2
Number of Medicare Beneficiaries

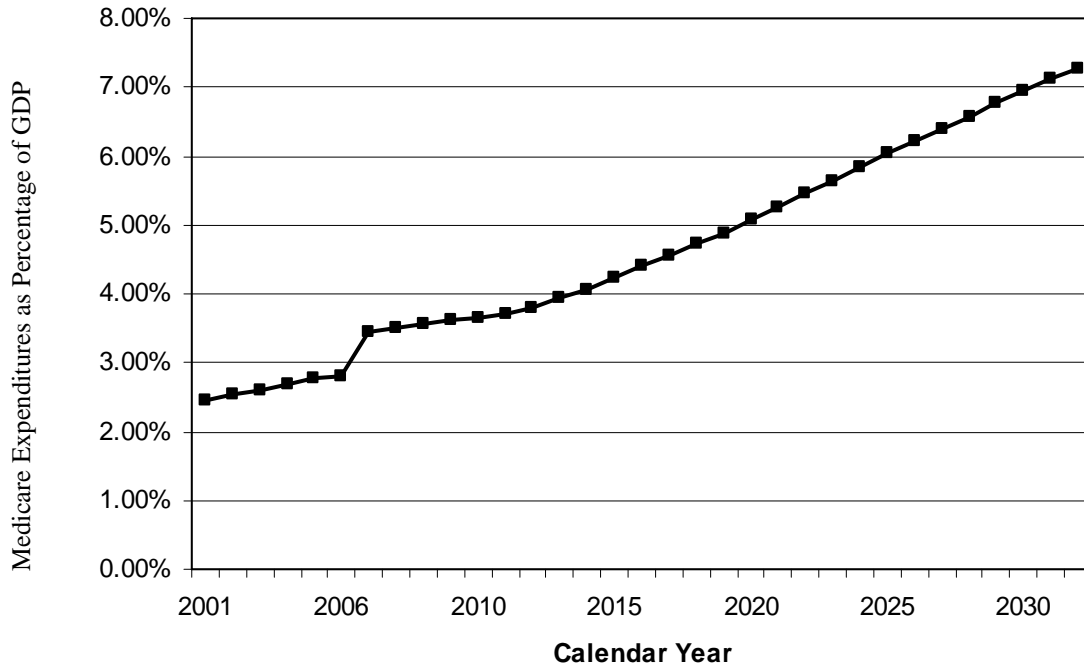


Source: Centers for Medicaid and Medicare Services, CMS Chart Series, Medicare Program Information, Profile of Medicare Beneficiaries, 2002. Online. Available: <http://www.cms.hhs.gov/charts/series/sec3-b1-9.pdf>. Accessed: June 1, 2004.

Note: ESRD means End-Stage Renal Disease; numbers may not sum due to rounding.

The projections for what Medicare will cost in terms of the overall economy are also scheduled to go up quite considerably in the future—from around 2.5 percent of GDP now to up around 7 percent by 2030. That's 7 percent of our entire economy, with increases due to a combination of more older Americans and higher health care costs. The prescription drug benefit alone may cost a couple of percentage points of GDP in 30 years.

Figure 1.3
Medicare Costs in the Future



Source: 2004 Trustees Report, Hospital Insurance and Supplementary Medical Insurance Board of Trustees.

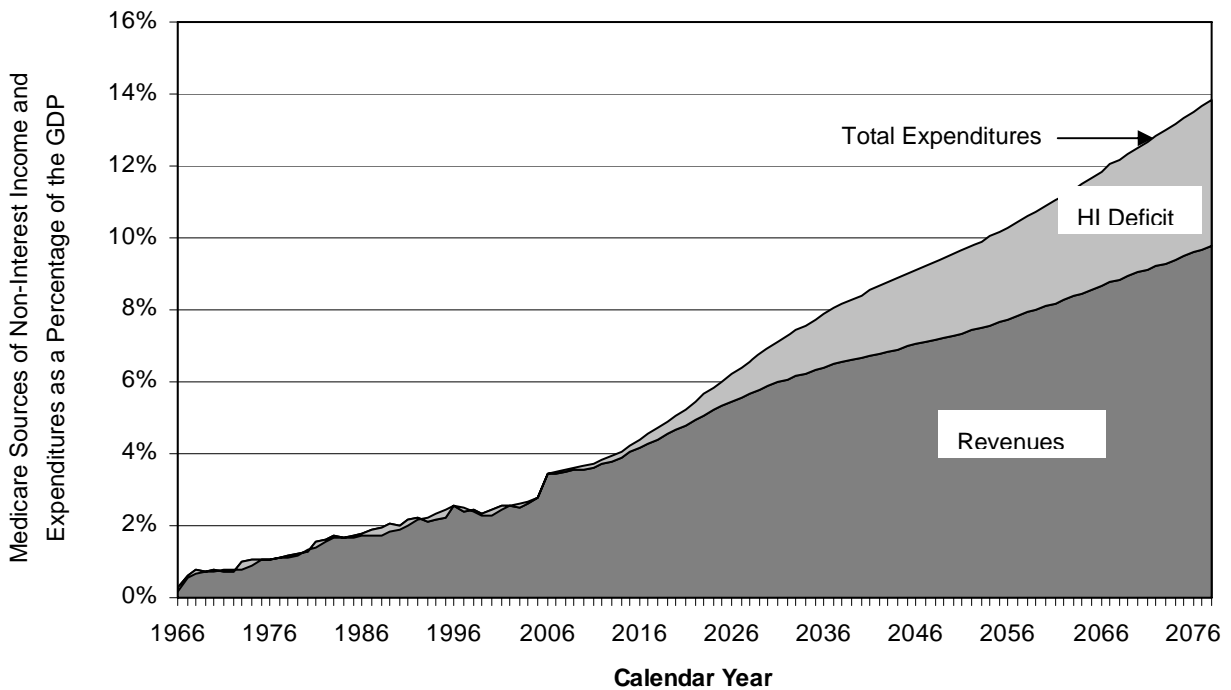
So what can we conclude? First, the number of older Americans will increase. The baby boomers are heading toward retirement. Second, health care costs will likely continue to increase. Health care costs were 5 percent of the economy in 1960 and were 15 percent of the economy in 2004. And they are projected by 2012 or so to be up around 18 percent of the economy. So health care costs continue to rise, and the number of older Americans continues to rise. Third, the health costs for older Americans will also likely continue to rise. Back when Medicare was first created, older Americans were paying about 20 percent of their total income for health care. Now it's back up around 20 percent again, and that trend is not heading down—if anything, it's going up.

Fourth, Medicare premiums are likely to continue going up. It's a tough proposition older Americans face. Looking at premiums as a percent of our economy, they've gone up from about one-tenth of a percent back in 1970 to about half of a percent of our economy, and are projected to go up to about a full percent of our economy within the next 30 years. So premiums are rising, and out-of-pocket costs are rising for the elderly.

All of these trends will increase pressure over time on Medicare. Each year, the Social Security Board of Trustees issues a report on the long-term outlook for Social Security and Medicare. The projection from the new trustees report indicates that Medicare will probably be the largest government program within 20 years, larger than Social Security. And within 15 years, the trust fund that finances the Medicare Part A program, the hospitalization costs, may be insolvent. (The trustees make projections over the next 75 years.)

Under these projections, over the next 75 years revenues grow considerably, but not anywhere near the increase in expenses. So if these projections are accurate, we'll be spending as much in 2076 on the Medicare program as we do now for our entire health care system for all Americans. Clearly, if this chart is any indication, we're going to be putting a lot of money into health care in this country in the years ahead (see Figure 1.4). Maybe we should all become health care workers! But remember, these projections for the future are just that—projections. There is a great deal of uncertainty about projections made this long into the future, and unforeseen events as well as future policy changes will certainly change these possible outcomes.

Figure 1.4
Medicare's Financial Outlook



Source: 2004 Trustees Report, Hospital Insurance and Supplementary Medical Insurance Board of Trustees.

If we take a snapshot of older Americans in 1960 and 2000 and then look ahead to 2030, we see that most projections show the poverty rate for older Americans continuing to decline modestly in the future (see Table 1.1). The percentage of uninsured likely stays very, very low due to Medicare. The percentage of the older population likely grows from 13 percent to 20 percent of our population. And health expenses as a proportion of overall income for the elderly—this is an extrapolation that I’ve made based on earlier work by Marilyn Moon—grows somewhere to around 25 percent of income.

Table 1.1
Older Americans: Yesterday, Today, and Tomorrow

| | 1960 | 2000 | 2030 |
|---|------------------|-------------|-------------|
| Poverty Rate | 35% | 10% | 5%? |
| Percent Uninsured | 44% | 2% | 2%? |
| Percent of Population | 9% | 13% | 20%? |
| Health Expenses (as a percentage of elderly income) | 20% (in 1965) | 20% | 25%? |

Source: Author’s calculations.

It is clear from this chart that the conditions that Lyndon Johnson faced in 1960 were very different from the conditions that we face in the future. The steps that we took during the Johnson presidency were incredibly important steps to enable the poverty rate and the “uninsurance” rate to go down as it has. If Social Security were gone tomorrow, half of all seniors would be back to living in poverty. And if Medicare disappeared tomorrow, the proportion of uninsured older Americans would be enormous. These critically important programs have filled significant gaps over the last 40 years.

But now we face new and tough challenges—a larger and growing aging population, as my generation ages, and health care costs that are clearly still rapidly rising. Fifteen percent of the economy is spent for health care now in this country, from 5 percent in 1960. Where will we be in 20 and 30 and 40 years? It’s hard to know. But we do know that we face some very big choices, and we also face some very big uncertainties.

These are large uncertainties. Are these projections that show health costs going through the roof accurate? It’s hard to know for sure, but past is prologue. Health care costs as a

proportion of our economy continue to grow. So it's likely that significant increases will occur if further steps are not taken. How much will health care inflation grow over the next 30, 40, 50 years? Predicting the health insurance system in America in the year 2078 is hard—a lot harder than trying to predict in 1935 what our Social Security system was going to look like in 2000.

The projections themselves based on current policies are one area of uncertainty. Another has to do with the uncertainty surrounding what will happen if we do take action—will policy changes made in the future have the expected impact? For example, in Social Security, if you cut the COLA (cost of living adjustment), you know what the impact will be—Social Security benefits go down. Dollars are saved, but people are made financially worse off. The impact of the policy change is clear. But if you make a change to the Medicare program—to hospital reimbursement rates, for example—will you reduce costs? And will that change positively or negatively affect the elderly? What actually happens? In the health arena, the impact of a policy change is often unclear.

There are great uncertainties, but we as a nation must still prepare as best we can for the future. It is our task as a people to come together and determine what we want for the future—for this program and for health care in general.

Several major options have been debated to strengthen Medicare in the 21st century. What we'll do in this symposium is to focus on three key choices. Two of them are on the cost side. Should the government be a much stronger, broader, and tougher regulator of costs and utilization of health care? Can that reduce costs? That's option number one. Option number two: should market-based mechanisms in the private sector be used in a much broader, tougher, and stronger way to try to control costs? Should we encourage the private sector to take over more of Medicare's responsibilities and use competitive forces so that beneficiaries are in a position to make choices about the kind of coverage they want? Will that reduce costs?

The third option, to the extent that either of the other two don't work, is do we want to raise revenues even further than are projected in the illustrations I've offered here? We could do that by raising premiums for older Americans, or raising payroll taxes on workers, or raising other taxes and the general revenues of the federal government. Or we could increase solvency by changing the eligibility age for the baby boomers so that Medicare doesn't start at 65—it might start at 66 or 67.

These are all potential ways to try to change the system. Every one of them, of course, involves trade-offs. But that's what we have to talk about. The main issue to me is how are we going to make sure that we have a strong and a vibrant system of health insurance coverage under Medicare for the next 30 years, the next 50 years, and even beyond?

The stakes are high. But I want to point out that the stakes were high back in 1965 and we as a people rose to the challenge and created a strong and vital Medicare system for older Americans. As we debate the future of Medicare, we will grapple with budget issues and with the technicalities of health insurance and adequacy issues. How we answer these questions goes beyond budget issues and technical issues, and goes beyond

adequacy issues. Our answers will say a lot about how we define ourselves as a people in the 21st century. Where do we draw that line between individual and collective responsibility? Should we rely more upon the market and the private sector or on government and a regulatory approach? Where do we as a people determine where our collective responsibilities start and stop?

These are very important issues. And the people who should talk about these issues are not only people like former Commissioners of Social Security, or politicians, or health care experts, but the American people. And that's our desire for the next two days—to hear not only from the experts who can help to frame the questions, but also from the public, who will live with the consequences of the choices that are made. The stakes are high because the choices we make about the future of Medicare will say a lot about how we define ourselves as a people. Let's choose wisely, for our sake and the nation's sake.