MEDICARE AND THE FUTURE OF RETIREMENT SECURITY


President Bush’s failed effort to privatize part of the Social Security program received a lot of attention from the media during the first half of 2005. Congressional efforts to begin privatizing the Medicare program over the last ten years have received far less attention. This absence of media attention may be one of the reasons for the success of some of these initiatives, especially those contained in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The media have focused, to a much greater extent, on the notion that Medicare cannot be sustained in its current form as baby boomers become beneficiaries over the next 30 years; the costs will just be too great.

The media, policy makers, and the general public would benefit enormously from the facts and analytical perspectives contained in each of these three books. Yes, Medicare, like everything else in health care, is expensive and its cost will grow substantially in the years ahead. The authors of these timely books, however, do a fine job of showing that Medicare cannot be reduced to cost issues only. And they have excellent credentials for doing so. Marilyn Moon is a former Trustee of the Social Security and Medicare Trust Funds. Christine Cassel is President and CEO of the American Board of Internal Medicine, following a career as one of the most distinguished geriatric physicians in the nation. And John Geyman is the former chair of the Department of Family Medicine at the University of Washington and is currently editor of The Journal of the American Board of Family Practice.

Although each of the authors approaches the Medicare policy debate from different angles, they share a common commitment to maintaining and strengthening the program for future beneficiaries. Cassel, in Medicare Matters: What Geriatric Medicine Can Teach American Health Care, focuses primarily on improving the quality of care received by beneficiaries by adjusting financial incentives to support more integrated models of care based on evidence-based medicine. Geyman, in Shredding the Social Contract: The Privatization of Medicare, offers a fiercely critical analysis of the motives for, and likely consequences of privatizing Medicare. Moon’s book, Medicare: A Policy Primer, is a comprehensive and methodical assessment of the many financial challenges facing Medicare, and a carefully rigorous analysis of alternative strategies policy makers might adopt in addressing them. Although Geyman is most explicit in his opposition to privatization, Cassel and Moon clearly think that further privatization would likely make health care less affordable and accessible for older people and that Medicare’s status as a social insurance program should be strengthened.

The three main organizing themes for these books may be described as identifying the value of Medicare in terms of its benefits and costs, the implications of current policy conflicts for the future of Medicare, and strategies to strengthen the program and protect the economic security of beneficiaries.

The Value of Medicare

According to most measures, Medicare is a public policy success story. In 1965, almost 50 percent of persons age 66 and older had no health insurance. Medicare now provides health care coverage for over 95 percent of the age 65+ population.

The longevity of persons age 65 and older increased steadily over the course of the twentieth century, and their health status, as measured by impairment levels, has improved, especially since the 1980s. The direct contribution of Medicare to these trends over the last 40 years, and any potential impact in the future, is difficult to determine with precision. The advent of Medicare is only one of several variables, including public health measures and the increasing educational achievement and economic resources of beneficiaries, that contribute to increases in longevity and improved health status. At a minimum, however, Medicare has increased access to health care and helped protect beneficiaries’ retirement resources, especially among lower-income beneficiaries.

David Cutler’s (2004) analysis of the costs and benefits of Medicare indicates that Medicare has helped
increase longevity and quality of life among beneficiaries. He notes that: “Since 1960 nearly two thirds of the life expectancy improvement (4.2 out of 6.6 years) is coming from people at older ages living longer. Life expectancy at age 65 has been rising recently, where historically it had not” (p. 6).

These contributions to the improved health status and economic security of older people have not come cheap; Medicare now costs over $300 billion a year and is set to grow rapidly over the next 30 years. The cost of Medicare is a major part of the rationale for expanding the role of the private sector in the program.

Privatization proponents argue that putting control of Medicare resources under private plans, especially health maintenance organizations (HMOs), will increase the program’s efficiency and cost-effectiveness. This rationale, however, for privatization has little, if any, factual support. It is based on an unwavering commitment to the free market ideology of neoliberal economics and public policy, which is largely immune to the factual realities of health care financing and delivery. Privatization advocates not only ignore the fact that Medicare has played a major role in increasing the longevity, quality of life, and retirement security of those ages 65 and older, they also overlook the embarrassing fact that Medicare is more efficient than the private insurance market, while covering a population that is at substantially greater risk of needing health care than populations covered under private plans.

According to Moon, from 1970 to 2000, Medicare achieved greater cost-containment than private plans after controlling for coverage of comparable services. Managed care interventions, mainly reductions in hospital lengths of stay, reduced cost increases in the private sector in the 1990s. Between 1999 and 2003, however, private insurance costs increased at about twice the rate of Medicare before returning to comparable annual cost increases in 2004. Moon estimates that when comparing rates of growth for comparable benefits, Medicare’s cumulative cost rate from 1970 to 2000 is 19 percent below that of private insurance. One of the major factors accounting for Medicare’s efficiency edge is its lower administrative costs, which constitute just 2 percent of total expenditures compared to 10–15 percent in private plans and much higher in many managed care plans, which have actually increased costs in the Medicare program.

Medicare HMO enrollees now cost 107 percent of what it costs to pay for fee-for-service (FFS) beneficiaries with similar risk characteristics. As poorly designed as the FFS system is to provide care efficiently, it is less expensive than private managed care plans in the Medicare context.

Further evidence of Medicare’s capacity to contain costs more effectively than the private insurance system comes from a recent Congressional Budget Office (CBO) report on Medicare spending growth over the last 28 years (White, 2006). The CBO analysis found that excess growth in Medicare spending per beneficiary declined from 5.5 percent during the 1975–1983 period to 0.9 percent between 1991 and 2003. Excess spending is defined as growth beyond the combination of the general rate of economic growth and the rate of change in the age composition among beneficiaries. The CBO attributes this slowdown in Medicare spending to provider payment policies designed to contain hospital and physician expenditures rather than increases in managed care enrollment, changes in Medicare cost sharing, or a system-wide spending slowdown.

Moon also points out that Medicare regulatory interventions designed to contain hospital and physician reimbursement rates have probably accomplished more sustained cost containment than any private sector initiatives such as managed care gatekeeping and hard bargaining in the 1990s, which generated cost savings that have been largely erased by large premium increases since 1999. It should be recognized, however, that steady advances in medical technology, the fragmented nature of the U.S. health care system, and the power of providers to set prices have frustrated efforts to contain costs through either government regulation or private-market mechanisms.

The Future of Medicare

Each of the authors note that after the fierce conflicts surrounding the creation of Medicare in the mid-1960s, which have been well described in recent books by Quadagno (2005) and Oberlander (2003), a bi-partisan consensus emerged in support of the fundamental structure of Medicare. In 1994, however, when the Republicans gained control of Congress, this consensus rapidly disintegrated as the Republican leadership began a systematic initiative to privatize Medicare by expanding the participation of managed care organizations (MCOs). This initiative culminated in the implementation of the Medicare+ Choice program in 1997. This program was designed to increase the percentage of beneficiaries in managed care, but fell far short of the 30 percent goal after an initial increase from 11 to 16 percent. Reimbursement rates were simply too modest to maintain increased MCO participation and the percentage of beneficiaries in managed care fell back to 11 percent in 2003 after MCOs began to withdraw from Medicare.

The Republican commitment to privatization, however, remains undiminished as demonstrated by the several privatization provisions embedded in the MMA of 2003. These provisions, which have received far less media attention than the bill’s prescription drug benefit, ensure that the political struggle over the design of the Medicare program will intensify over the next several years and become increasingly salient with the rapid growth of the beneficiary population and increasing threats to private and public sources of retirement security.

Moon, who has been one of our most insightful analysts of Medicare policy and politics for many years, thinks that the outcome of this protracted struggle will be shaped by five fundamental issues, including the doubling of the beneficiary population by 2030. The other four issues are the glaring gaps in Medicare coverage, which include long-term care,
dental care, the two year waiting period for disabled adults younger than age 65, and coverage limits in the drug benefits (the doughnut hole); the limited economic capacity of most beneficiaries to pay more out-of-pocket for health care (median beneficiary income is only $17,000); the impact of changes in the overall health care system (technology-driven cost increases); and, the fiscal capacity of the federal government to support Medicare (tax cuts, revenue flows, and competing policy priorities).

Each of these issues is deeply implicated in the debate over privatization, which the three authors think will largely undermine the capacity of the public sector to manage them in the interests of beneficiaries and their families. Geyman and Moon are especially emphatic in their beneficiary-oriented opposition to privatization, which would likely engulf Medicare increasingly in the cauldron of cost, access, and quality of care deficiencies that currently characterize the private health care system. The U.S. system costs far more than health care systems in any other developed country, provides fewer services per capita, and generally poorer quality of care outcomes with greater disparities between groups (social, ethnic and socio-economic) in access to care, and leaves a greater percentage of its population uninsured.

The failure of past efforts to use managed care as a privatization vehicle has not lessened the enthusiasm of privatization supporters for a greatly expanded managed care role in the Medicare program. The MMA includes a large increase in reimbursement levels for HMOs, which supporters hope will induce HMOs to recruit more Medicare members by offering benefits not available in traditional Medicare. This is the rationale for making managed care a more expensive option than FFS on a per-capita basis. Managed care was once thought to be less expensive because it was more efficient than FFS care. The goal now, however, appears to be privatization regardless of the cost. After all, much of the increased cost of privatization will be used to enhance corporate profits and are as likely to be borne by beneficiaries of the government. Geyman notes that:

"There is a fundamental irony and disconnect in the conservative agenda as it relates to Medicare. Conservative legislators and the current Administration continue to cry out against Medicare as an inflationary entitlement program which we cannot afford, yet fashion legislation which dramatically increases its costs and imposes scant cost containment provisions. They are advocates not of fiscal responsibility but of handing over nearly blank checks to the private healthcare marketplace." (p. 62)

As designed, the drug benefit will provide substantial assistance to the 7 million beneficiaries with incomes between 150 percent of the federal poverty level and the Medicaid eligibility level and with $6,000-$9,000 in assets, and the 2 million or so who spend more than $5,100 annually on drugs. For most beneficiaries, however, the drug benefit is too limited to be considered an adequate insurance product. The initial premium, copayments, and deductibles will limit the benefit's value for beneficiaries with relatively low annual drug costs. The absence of any coverage for those spending between $2,150 and $5,100 annually on drugs (the doughnut hole) further diminishes the benefit's value for between 40 to 45 percent of beneficiaries who need assistance with their drug costs within this range. Only 5 to 15 percent of beneficiaries will benefit substantially from the catastrophic coverage, which pays 95 percent of all costs over $5,100 annually.

In the absence of any feasible constraints on drug prices, such as allowing the federal government to negotiate prices with drug companies, Geyman and Moon point out that the drug benefit will not do much to contain out-of-pocket drug costs over the next several years for most beneficiaries. The benefit will cover only 22 percent of the projected costs beneficiaries are expected to spend on drugs between 2004 and 2013. Premiums and deductibles will increase by 78 percent between 2006 and 2013, much higher than beneficiaries' projected income growth, and catastrophic coverage will rise from $5,100 to $9,066 in 2013, all of which will make the benefit less affordable each year after 2006, which is likely to make the ten year, $700 billion plus cost of the program increasingly difficult for the public to accept.

In addition to enhanced payments to MCOs, the privatization related provisions in the MMA also include the following:

- Administered through private companies rather than through the Medicare program, which will add expensive layers of administration and help HMOs consolidate their position in Medicare
- A managed care versus traditional Medicare experiment to begin in 2010 in six metropolitan areas
- A health savings account program that many privatization advocates would like to see imported into the Medicare program as a premium support approach to privatization
- A Medicare solvency provision that calls for Congress to consider alternative financing strategies once Medicare's general revenue reached 45 percent. This could create an opportunity for increasing the share of cost borne by beneficiaries.

These provisions are designed to alter the traditional Medicare program "in ways that could ultimately shift the public-private balance and lead to long-term structural changes" (Gold, 2005, p. 1303). The MMA includes a provision that will increase annual payments to private plans by the larger of either, a 2 percent increase (the pre-MMA standard) or the national percentage growth in health care costs (6.6 percent in 2005), regardless of the extent to which plans benefit from favorable selection among beneficiaries who chose to join them. The overall effect of this payment arrangement and the other subsidies will raise the cost of private plans in Medicare Advantage (the MMA managed care option) from 107 percent to 116 percent of what Medicare pays for the same beneficiary in traditional Medicare. This extra money, in combination with an integrated Part D (drug) benefit and the
continuing capacity of private plans to benefit from favorable selection, will make it possible for the plans to offer benefits (low or no co-payments and premiums) not available in traditional Medicare, at least in the short-term. Geyman notes that between 1999 and 2003 the average out-of-pocket costs of Medicare managed care members increased from $976 to $1,964 and for those in poor health, from $2,632 to $5,305. In 2003 the Congressional Budget Office (CBO) projected that:

... private Medicare plans will cost 8-12% more than the traditional fee-for-service Medicare program. If lower costs are factored in because of more favorable risk selection with healthier seniors enrolling in private Medicare plans, overpayments to private plans, including bonuses provided for in the 2003 MMA, are projected to be 25% more than traditional FFS Medicare. Unfortunately, current methods to adjust payments by risk of enrolled populations in private plans are still inadequate. (p. 92)

New and presumably improved risk adjustment procedures for payments to private plans will be implemented in 2007. The repeated failure, however, of risk adjustment models to predict more than a small percentage of future health care costs does not inspire confidence that the new model will do much to contain costs.

The MMA requirement that prescription drugs be administered by private plans is an important step toward Medicare privatization. Supporters of this provision claim that it will increase market-based competition in the program, and is a better method of containing drug benefit costs than having the federal government negotiate reductions, as is now done by the Veterans Administration, the military, and some state Medicaid programs. The real motives, of course, are to provide financial incentives for the spread of private plan participation in Medicare, and to erode the notion that Medicare should administer benefits directly as it has done historically. Private plan administration, like the legislated inability to negotiate drug prices, is likely to add to the cost of the Medicare program.

These increased costs will hasten the day when the general revenue (GR) portion of Medicare funding will exceed the 45 percent cap, which was included in the MMA as another method of potentially increasing the beneficiary-borne share of Medicare costs. The 45 percent GR rule is not a comprehensive, undistorted indicator of Medicare’s fiscal status. It is an arbitrary method designed to set the stage for dramatizing the ideological perspective that federal spending on Medicare is excessive and must be limited by increasing costs to beneficiaries (Moon, 2005).

The MMA provision, mandating six demonstration projects beginning in 2020, is designed to test the competitive advantage of managed care versus the traditional Medicare program. The latter, however, is likely to be at a major disadvantage because it will be reimbursed at levels no higher than the average level for HMOs and preferred provider organizations (PPOs) in the demonstration sites, even though they are likely to be serving sicker, higher cost beneficiaries for whom the traditional program is the provider of last resort.

If managed care plans cost more than traditional Medicare, what about their effectiveness in terms of health care outcomes and consumer satisfaction? As Geyman notes, the existing research provides no evidence in support of managed care’s (mainly HMOs) superiority in comparison to the regular FFS programs. In fact, the findings from this research tend to move in the opposite direction—better outcomes in the FFS system.

A study by Ware, Bayliss, Rogers, Losinski, and Tarlov (1996) found substantial differences in 4-year outcomes for elderly and poor, chronically ill patients treated in HMOs versus fee-for-service systems in four urban areas. For elderly patients (those aged 65 years and older) treated under Medicare, declines in physical health were more common in HMOs than in FFS plans (54% vs. 28%; p < .001). In one site, mental health outcomes were better (p < .05) for elderly patients in HMOs relative to FFS, but not in two other sites.

Goldzweig and colleagues conducted a study comparing rates of cataract extraction in prepaid health settings versus those in FFS settings in southern California (Goldzweig, Mittman, & Carter, et al., 1997). The study included more than 62,000 Medicare managed-care enrollees in a staff model HMO and an Independent Practice Association (IPA), and 47,150 FFS Medicare beneficiaries (a 5 percent sample of all southern California FFS beneficiaries.) After controlling for age, sex, and diabetes status, FFS beneficiaries were twice as likely to undergo cataract extraction as prepaid beneficiaries were.

The most recent study by Safran, Wilson, Rogers, Montgomery, and Chang (2002) is based on data from 8,828 respondents (Medicare beneficiaries) who were in either the Medicare FFS or Medicare HMO in 13 states with Medicare HMO markets. The authors found that the traditional FFS Medicare system performed better on 9 of 11 quality care outcomes that were examined in the study.

The results did not differ for patients in better or worse health, and the relative performance of the systems was the same in all 13 states, with the exception of one staff/group-model HMO that outperformed FFS and IPA/networks in its area (Arizona) on three aspects of care. The findings are markedly consistent—in both direction and magnitude of effect—with previous comparisons of indemnity and managed care systems’ performance on the defining elements of primary care. (Safran, Wilson, Rogers, Montgomery, & Change, 2002, p. 757)

The MMA also includes an expansion of the Medical savings account program which was initiated in the Balanced Budget Act of 1997 and that many privatization supporters envision becoming a vehicle for converting Medicare from a defined benefit to a defined contribution program. Medical or health savings accounts (HSAs) are strongly supported by the Bush Administration as part of its “ownership society” agenda and as its preferred strategy for containing costs and increasing insurance coverage. The essential features of this approach, which is often referred to
as “consumer driven” health care include a tax sheltered health savings account with capped annual contributions, a catastrophic insurance plan and out-of-pocket purchasing of health care until the annual catastrophic plan deductible of $1,000 to $2,000 for individuals and $2,000 to $4,000 for families is reached. Catastrophic insurance premiums and deductible levels are likely to increase as the number of those with HSA plans grows and the percentage with more expensive health care needs expand, driving up average out-of-pocket expenditures. The rationale for consumer-directed care is that by making consumers responsible for a greater share of their health care costs, they will become prudent purchasers of the care they receive, which will reduce increases in overall health care spending.

The ultimate objective of the Medicare privatization proponents may be to support the emergence of HSAAs as a vehicle for converting Medicare to a premium support program based on vouchers that beneficiaries would use to purchase a high deductible catastrophic coverage plan and set up tax sheltered savings accounts for out-of-pocket expenditures. This approach would accelerate the shifting of costs to beneficiaries, allow the federal government to cap expenditures, make Medicare a defined contribution insurance program and create a windfall for financial institutions, which have recently flocked to the private HSA market as employers move to limit their health insurance costs by shifting them to employees in HSA plans. According to Moon, vouchers would:

...offer less in the way of guarantees for continued protection under Medicare. They are most appealing as a way to substantially cut the federal government's contributions to the plan indirectly, by eroding comprehensive coverage that the private sector offers, rather than as stated policy. The risks under such a plan would be borne by beneficiaries, which is of particular concern in an era when pensions and retiree health benefits from employers are less certain and Social Security benefits may be reduced. Retired persons' level of risk is increasing, and a key issue is whether it is advisable to shift even more risks onto individuals. (p. 152)

Importing defined contribution strategies like HSAs into the Medicare program would also undermine one of the program's greatest strengths, as described by Cassel:

The strength of the Medicare contract lies in its inclusivity and stability. Many current initiatives favor dividing the risk pool into independent managed-care plans and instituting medical savings accounts ... This approach would limit the cost to government and place a higher cost burden on patients. Such plans are being advanced as a positive development because they would make Medicare more like commercial insurance. Ironically, they come at a time when commercial insurance is reducing coverage, raising premiums, and shifting costs to patients. Following the commercial market would actually reduce the sense of security.

The introduction of such market-based proposals raises the question of whether we are losing the solidarity that underlies Medicare's success. (p. 208)

Finally, the MMA includes a requirement that individuals earning over $80,000 and couples earning over $160,000 pay more for their Part B premiums. The premiums for these beneficiaries are scheduled to increase in subsequent years. The provision affects only about 3 percent of current beneficiaries. The principal purpose of this provision is to get the nose of the means-testing camel into the Medicare tent and then gradually move the requirement down the income ladder in the future. In order, of course, for means testing to produce significant savings, the threshold would have to be set at a level far below $80,000 and involve far more than 3 percent of beneficiaries, which would essentially destroy Medicare as a universal entitlement program by turning it into a means-tested program like Medicaid.

Medicare and Retirement Security

Moon usefully places the Medicare policy debate in the context of retirement security, which is threatened by several trends that have emerged over the last three decades and that are likely to strengthen in the future. The greatest threat to retirement security may be the projected increase in retiree out-of-pocket health care costs over the next several decades, which will occur under current provisions in Medicare law. These costs would rise higher if Medicare undergoes further privatization through conversion to a defined contribution program based on a premium support strategy. This approach would also erode beneficiary choice of providers and access to services by making FFS care increasingly unaffordable and managed care the only feasible option for low-to-moderate-income beneficiaries with expensive-to-treat chronic health conditions. This erosion of choice and control would occur without any realistic prospect, given the cost history of managed care, of containing Medicare expenditures. For each of our three authors, preventing Medicare privatization is crucial to containing beneficiary out-of-pocket costs, preserving choice and access to high quality services, and cushioning the impact of the other growing threats to the economic security of current and future retirees.

These threats include the rapid decline in defined benefit private pensions and their replacement by poorly funded defined contribution plans (401(k), IRA); the underfunding of many of the remaining defined benefit plans in both the private and public sectors; the meager savings and stagnant incomes of most working families; the increasing costs of education, housing and health care; the declining wage replacement value of Social Security; and the attack on Social Security by conservatives who want to privatize the program by turning it into a defined contribution plan similar to the tax-sheltered savings and investment plans now dominant in the private sector. The collective impact of these trends, according to Munnell...
and Soto (2005), may cause baby boomer retirees to look back on the current period as the “golden age” of retirement income.

Today’s retirees are claiming Social Security benefits before the rise in the retirement age to 66 and then 67, which is equal to an across-the-board cut in benefits. Today’s retirees also do not face the huge deductions in their Social Security check to cover Medicare premiums for Parts B and D that tomorrow’s retirees will. And today, the average retiree does not pay personal income tax on his Social Security benefits, whereas future retirees will increasingly see a portion of benefits subject to taxation. Finally, most of today’s retirees are covered primarily by a defined benefit plan and do not face the uncertainty associated with the inadequate lump-sum payments from 401(k) plans. (p. 4)

Medicare beneficiaries have been experiencing a steady growth in out-of-pocket spending for health care for several years. This percentage of discretionary income spent on Medicare premiums, copayments, and deductibles has increased from 15 percent in the 1980s to 22 percent on average (Caplan & Brangan, 2004) and is now over 30 percent for lower income beneficiaries. These increasing costs have put routine medical care beyond the reach of many less affluent older people who constitute, as Moon demonstrates in one of her early chapters, a majority of Medicare beneficiaries whose incomes are under $30,000 a year. Adding a prescription drug benefit to Medicare will help reduce out-of-pocket costs for some retirees, but many older people will not have adequate access to health care until Medicare co-payments and deductibles are reduced and long-term care, which is now available under Medicaid for only the impoverished, is made an affordable Medicare benefit.

The fact that employers are dropping or sharply curtailing their retiree insurance programs is also increasing out-of-pocket health care spending among retirees. As Geyman reports:

Trends in retiree health coverage add to the already serious problems U.S. seniors have in affording health care. Between 1988 and 2003, the proportion of U.S. employers with more than 200 employees providing such coverage dropped from 66 percent to 38 percent. In addition, most retiree health plans have required sharp increases in cost sharing in recent years, with about two in five retirees now responsible for all of their coverage. The Employee Benefits Research Institute, a non-profit research group in Washington, D.C., now estimates that retirees will need to have saved up to $200,000 to pay for their health care expenses in retirement. Given present trends, Watson Wyatt Worldwide, a benefits consulting firm in Washington, D.C., projects that employers will cover less than 10 percent of their retiree health care costs by 2031. (p. 73)

Current projections (Johnson & Penner, 2004) indicate that Medicare beneficiaries’ out-of-pocket expenditures will rise from 22 percent in 2030 to between 30 and 40 percent in 2030 and health care spending, as a share of after-tax income for married couples, will rise from around 20 percent in 2000 for those in the bottom 40 percent of the income distribution to between 48 to 52 percent in 2030. These projected increases represent a profound threat to the economic security and health status of future retirees and their families.

Health care costs are likely to increase at essentially the same annual rate for the next several decades as for the past 30 years. The continuing development and increasing use of medical technology, the huge growth of the age 65+ population and a profit-driven health care system with high administrative expenses will push costs higher, even with significant improvement in the overall health status of the Medicare population. Significant reductions in technology costs may not even be cost-effective. Technological innovations in the treatment of heart disease are responsible for major increases in longevity and quality-of-life improvements (Cutler, 2004) and largely represent resources well spent, even though initial costs to develop the technologies were enormous. Increased longevity drives up health care costs, but few would question that the benefits are worth the cost.

More rigorous, objective cost-benefit assessments of new products and payments based on quality-of-care outcomes could improve the efficiency of technology utilization and practice patterns, but there is little reason to think that assessments and payment incentives will substantially reduce the cost of health care. This is a major reason that in a recent simulation analysis by Rand researchers (Goldman, Shang, & Bhattacharya, et al., 2006) project cost increases for the next 20 years that are very close to what we have experienced for the last 30 years for the Medicare program. The future of health care will, in all probability, be characterized by improvements in the quality of health care and better treatment outcomes as well as a growing population of people who need health care and who will increasingly benefit from the care they receive. These developments may generate cost increases that exceed those of the past and make health care an increasingly larger share of the total economy.

Many assume that if health care becomes 25 percent of the GDP by 2030, the overall economy will be damaged in some fundamental way—that we simply cannot afford a health care economy of this size. It is far from clear, however, that the costs will outweigh the benefits of an expansive health care sector if it occurs in the context of overall economic growth and steady increases in productivity. In her book, for example, Moon shows that workers in 2030 are projected to generate 55,000 more in per worker GDP on average than the current 67,000 per worker. She also notes that costs per Medicare beneficiary are projected to increase at a lower rate than productivity increases, making it necessary for workers to pay only 7 percent more than they do now in 2030 from incomes that are likely to be far higher (50 percent or more higher). This means that workers will be in a better position to pay for Medicare cost increases than will beneficiaries who
will experience greater out-of-pocket health care spending.

**Making Medicare Better**

None of the authors would be satisfied with just preventing privatization and leaving the program otherwise unchanged. Their policy recommendations are designed to remedy several deficiencies in the current program, including amendments to the MMA that would remove the prohibition on the government negotiation of drug prices and eliminate the doughnut hole. Cassel recommends that new reimbursement strategies be designed to reduce fragmentation by providing incentives to offer more integrated care with a geriatric focus and closer adherence to evidence-based practices. She thinks managed care is the most effective organizational structure for integrating care, but recognizes that most HMOs have focused more on the bottom line than improving the quality of care they provide their older members. She describes several models of well coordinated, geriatically oriented care, but they are provided by non-profit organizations like Kaiser-Permanente, which constitute a diminishing percentage of HMOs. She also suggests that we should soon begin to address the need for systematic rationing of health care, but is rather vague about how it should be done, except that it should not be age-based and should somehow incorporate evidence-based guidelines and standards of care.

Geyman provides a lengthy list of recommendations designed to contain profligating, eliminate waste by using evidence-based standards to reduce regional differences in practice patterns, improve benefits, and ensure that Medicare remains affordable for beneficiaries and taxpayers. He agrees with Cassel that provider incentives and, if necessary, regulatory procedures should be used to institutionalize evidence-based practices in Medicare, which Mark McClellan, the current administrator of the Centers for Medicare and Medicaid Services, appears to support as well with his “pay-for-performance” initiative.

Moon describes several taxation options that could be used to keep Medicare solvent over the next four decades. She suggests that some compromise combination of increased taxes and modest increases in beneficiary cost sharing will likely emerge over the next several years as policy makers are finally forced to drop their ideological blinders and subservience to corporate donors and begin to address the challenge of Medicare and health care affordability generally, in a seriously pragmatic fashion.

Moon recommends a strategy that progressive supporters of Medicare should adopt now as a vehicle for improving coverage and controlling beneficiaries’ out-of-pocket expenses. The proposal, which was initially, and more fully presented in an article by Davis, Moon, Cooper & Schoen (2005) would cap out-of-pocket spending at $3,000 annually, eliminate the prescription drug doughnut hole, and offer a competitive alternative to Medicare Advantage (managed care) and current Medigap plans by adding a comprehensive benefit option (Medicare Extra, Part E) to the Medicare program. The benefit (Part E) would reduce the annual deductible for hospital and physician services from $1,226 to $250.00; reduce physician cost sharing from 20 to 10 percent; eliminate the prescription drug deductible and limit cost sharing to 25 percent for all purchases (no doughnut hole); set premiums for all Medicare components, including the new Part E benefit, at a new benefit premium level which would cost $92.00 a month (and cap out-of-pocket costs at $3,000 annually. Two of the major advantages of this proposal are that it would level the playing field for the fair market test of managed care and traditional FFS programs, and eliminate the need for beneficiaries to use multiple sources of coverage (private Medigap insurance) to obtain comprehensive benefits.

I think this approach is not only sound public policy, but could also be an effective political strategy that builds on the wide and deep popularity of the traditional Medicare program. It offers a relatively comprehensive alternative to privatization through managed care and HSAs and takes the progressive program for Medicare reform beyond a mere patching up of the MMA legislation. Moon’s Part E strategy represents a positive response to the privatization threat and could help shift the balance of public opinion against policy elite efforts to make Medicare indistinguishable from our failing private health care system.

Each of these books is a valuable contribution to the body of information we need to understand what is at stake in the debate over the future of Medicare. Moon’s book, however, is especially important; it is, in my judgment, the best single text now available on Medicare. Her book is a carefully organized and highly accessible analysis of the major Medicare policy issues, written with a quiet sense of urgency that gives vitality and clarity to her discussion of several technical issues normally reserved for only the most “wonkish” of readers. Her book is both a primer for those seeking a basic understanding of the Medicare program, and a guidebook for those interested in taking an informed stance on the future of Medicare and the economic security of older people and their families.

A kind of slow motion “showdown” over the fundamental structure of Medicare has been underway for several years and is likely to accelerate in the future as the beneficiary population grows, health care costs increase, and federal budget deficits accumulate into the trillions. Privatization proponents will use the deficits to justify steady increases in beneficiary cost sharing, which is already set to almost double for many beneficiaries over the next 30 years, while continuing to press for more deficit-expanding tax cuts. If the privatization inroads contained in the MMA legislation are not repealed, beneficiary costs will increase and Medicare may be dismantled slowly enough to prevent the kind of political backlash that quickly undermined President Bush’s Social Security privatization initiative. Privatization opponents should make amending the MMA part of a more comprehensive strategy to resist privatization, including the kind of
program enhancements described by Cassel, Geyman, and Moon, especially the latter’s Part F proposal. In addition, a comprehensive “push back” strategy should include fiscal policies designed to reduce projected budget deficits.

The fundamental contradictions between tax cuts, increased military spending, and adequate funding for Social Security, Medicaid, and Medicare cannot be managed through deficit budgeting for much longer without destroying the fiscal foundations of our hard-won systems of social insurance that support retirement security for millions of older people now—and millions more in the future. The stakes of this struggle could hardly be higher and the valuable contributions of these authors could hardly be more timely.

Larry Polivka, PhD
School of Aging Studies, College of Arts and Sciences
Director, Florida Policy Exchange Center on Aging
University of South Florida
Tampa, FL 33620

References
Ware, J., Bayless, M., Rogers, W. Kosinski, M. & Tanzer, A. (1996, Oct 2). Differences in 4-year health outcomes for elderly and poor, chronically ill patients treated in HMO and fee-for-service systems: Results from the medical outcomes study. Journal of the American Medical Association, 276, 1039–1047.