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I have chosen as my topic for tonight a subject that is familiar to many of you in your everyday lives, familiar to some of us in your professional lives, familiar to some in our family responsibilities, ultimately important to all of us as we grow older. It is of significant political and economic importance. Medicare, its funding and reform, the coverage of prescription drug benefits under the plan, and the solvency of the program is a much talked about little understood vital piece of the American social fabric which repeatedly has served the role of political football in debates and campaigns. This evening I plan to review the history of Medicare, its current condition and future prospects and make a suggestion as to the model to be used for future reform. As is usually the case in the debates concerning important social issues, the common media, by which I mean news papers like the Holland Evening Fish Wrapper and the Lakeshore Firestarter, weekly news magazines, evening TV news reports and special interest journals (AARP publications and most medical professional mouthpieces) cannot be relied upon to present a factually complete, balanced and thoughtful analysis of the issue. Understanding of the issues in this debate is never complete or easy and I will not this evening be able to provide all the answers or all the questions that should be asked. However, there are comprehensive sources of information on the subject available that will help to explain the issues and will impress upon the reader its complexity and the unpredictability of the underlying predictions.

First a historical perspective. Medicare was implemented in 1966 under President Johnson to insure a minimum of medical care benefits to persons over the age of 65. It now also covers individuals with certain disabilities and has grown from a membership of 19 million to 40 million. The expenditures for Medicare have risen faster than those of any other major federal program and now cover one of every seven Americans. Because of the aging of the baby boom generation and the likelihood of growing increases in medical expenditures it remains in the forefront of political debate. By 2030, the program is expected to cover 77 million or 1 in 5 Americans and to account for 4.5% of the Gross National Product.

The implementation of the Medicare program had two immediate effects. The use of health care serves grew and financial burdens on older Americans and their families for medical services declined. The benefits package has changed little since 1966 but has generally kept up with the advances in medicine over those years. Health care policy experts and public health analysts agree that the increase in life expectancy seen since 1966 is attributable in part to Medicare and the financial availability of medical services. For a 65 year old female life expectancy has increased from 15.8 years in 1960 to 19.2 in 1998 and for men from 12.8 to 15.9 in the same period. In addition, life expectancy has increased at a faster rate for the 65 and older than for any other group – 24% versus 7.6% for those at birth. In 1965, the elderly (over 65) spent 19% of their income on health care. It dropped to 11% in 1968 but is now up to 20% in 1998. Medicare copayments and premiums (the means by which recipients cover the gap between Medicare benefits coverage and the actual billed cost) rose an average of 9% per year which is faster than the growth of average income in this group.

As the program acquired more enrollees and the elderly population grew so did Federal expenditures.

In an effort to control the rise in expenditures in Medicare over the past 35 years, the Health Care Financing Administration (HCFA) now replaced by Medicare and Medicaid Services (CMS) instituted changes in the manner in which re-imbursement was provided to hospital (Diagnosis Related Groups or DRG's) and limited the use of home health care and skilled nursing care. These efforts slowed the rapid rise in Medicare expenditures in the late 1980s so that per-capita Medicare expenditures grew at a slower rate than those of the private health insurance industry from 1970-1997. In more recent effort to slow the growth of expenditures, Medicare beneficiaries have been allowed to enroll in HMO's instead of remaining in the traditional controlled fee-for-service program. However, in general, these programs have not been successful in reducing costs with the costs to HMO's for these enrollees averaging more than if the same individuals had remained fee-for-service. These excess costs were absorbed by the HMO as part of their risk of providing coverage and explains why many of these programs have been dropped throughout the country. Dropping of these programs has been the source of many news briefs in which HMO's have seemed heartless and cruel. In reality, they merely reacted in the expected economic fashion by eliminating programs that were unprofitable for reasons of inadequate reimbursement from the federal government and inefficient management.

Presently, in any discussion of the condition of Medicare and its reform, there are three major issues. First, since the late 1970's, federal legislators have sought to revise the program in order to improve its management and efficiency and thereby slow the growth of federal expenditures. This legislative involvement leads to the taking of sometimes extreme political positions for public consumption. Second, Medicare's benefit package is inadequate. Medicare does not pay for prescription drugs and the deductibles and copayments can be very expensive. About 85% of Medicare beneficiaries have some type of supplemental coverage and they pay more for their health care then do most other Americans – both in absolute dollars and as a share of their total health care expenditures. Excluding long term health care costs, the average beneficiary pays more than $3,000 per year of out of pocket costs. Thirdly, Medicare has not been as well financed as Social Security leading to numerous fiscal crises.

These three issues overlap and advocates of various reforms often have conflicting agenda items. For instance the desire to slow growth in expenditures while proposing coverage of prescription drugs and being unwilling to change the mode of financing the programs to place a greater burden on those most able to pay – a needs based premium program or benefits package.

Moves to reform Medicare and proposed programs to accomplish this are a regular staple of Capital Hill. The most significant recent event was the National Bipartisan Commission of the Future of Medicare which was formed as part of the Balanced Budget Act of 1997. It went out of business in March of 1999 unable to reach supermajority

consensus on a set of recommendations. The Commission's world view was based on five interrelated propositions which time has proven partially or totally inaccurate. First that because of the baby-boom generation and the continuing propensity of medical care cost to grow faster than the rest of the economy, Medicare faced a short and medium term financial crisis. Second, given the tax burdens already imposed on the average tax payer for Social Security and Medicare, the programs could not be sustained at their present levels for the future when the pool of eligible enrollees comes of age. Tax payers would revolt and an increased tax drag on the economy would be unsustainable. Third, after 15 years of squeezing the providers' adjustments to reimbursement systems (read reduction in compensation to providers) had largely run its course. Fourth, the beneficiaries had not been squeezed as much as possible given the continued very high rate of utilization of services by this group. In other words, attempts to reduce utilization by the elderly would be the most effective way of controlling cost in the long run. And finally the best way to encourage cost control by reducing utilization would be to promote price competition among fully capitalized health plans – i.e. the HMO model spoken of earlier.

However, the events of the past five years, despite the recent recession, have brought many of these propositions into question. Quite simply the American economy grew at a much faster rate than any of the official forecasters had predicted – indeed at a much faster rate than any of the prevailing macroeconomic models, on which such forecasts are based, considered possible. Revenues flowed into the Social Security and Medicare trust funds and into the general coffers of the federal government in far larger amounts than anyone could have imagined. As a result, the short-term crisis of the Medicare trust fund has disappeared and there is reason to question whether there really is a long term crisis. Before the enactment of the Balance Budget Act of 1997, it was projected that the Hospital Insurance Trust Fund (Medicare Part A) would be insolvent in 2001. After the Balanced Budget Act of 1997 that date was moved to 2008 and now is project to be 2029 long past the time about which any rational economic forecaster would attempt to make predictions with any degree of certainty. Medicare should continue to be in the best financial condition it has been since its inception throughout the remainder of this decade. Reductions in outlays due to the Balanced Budget Act of 1997 and improvements in the program's operational efficiency have contributed to this improved situation but it is largely due to the strength of the economy and the concomitant growth in Medicare revenues. This fact should serve as an important reminder that, over time, the most important element in any equation involving public expenditures is the growth of the nation's economy, which determines how much can be spent for public purposes at any given level of tax burden.

All this being said, the motivation for reforming Medicare is and should be more than financial. The traditional Medicare program was modeled after the indemnity insurance plans that dominated the organization and delivery of health care in the 1960's. "Aetna were glad we met you" was the way the adds went at that time. Indemnity insurance was the primary way in which medical care was paid for in America. Services were rendered by hospitals, physicians and labs, bills were submitted and payment was received. However, there have been major changes since then in the organization and financing of health care, as well as in the benefits that are typically provided. Health care under

Medicare should be similar to that provided to the rest of the American public. This was an important principle when Medicare was first established, and is important now as well.

The Medicare benefits package is inadequate as compared with insurance plans provided to most employees. Unlike almost all other health plans, Medicare effectively offers no coverage for prescription drugs for outpatients and no protection against very large medical bills. Medicare has also struggled with the best way to make decisions about whether or not to cover procedures using new forms of technology and has often lagged behind private carriers in approving these services. In addition, the amount spent by Medicare varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health status. Since beneficiaries all pay the same premium on Part B services, these variations result in significant cross-subsidies from people living in low-cost states with conservative medical practice styles to people living in higher-cost states with more aggressive practice styles.

A Medicare program reconfigured to resemble the Federal Employees Health Benefits program represent a better structure of Medicare. This plan is a premium-support program – that is, the government's contribution is the same regardless of the plan chosen by the beneficiary. It has been in existence for many years. This is not a new idea and has been proposed as a model for Medicare reform for more than 20 years and for health care reform more broadly. It has received bipartisan support in Congress including Sen. Bill Frist of Tennessee and Sen. John Breaux of Lousiana. It would work like this. Every year beneficiaries would choose from a wide variety of plans, including a publicly administered fee-for-service plan. Before the selection period, they would receive information about the plans available in their geographic areas. The federal government would certify plans for eligibility. Eligibility requirements could include a minimal level of financial reserves, specified availability of providers, a minimal benefits package, and regular reporting to plan members of performance. Beneficiaries could choose the level of coverage including a "high-option" plan which would cover prescription costs for instance. The government would negotiate with private plans to set prices and a national premium would be set. This would be paid per member regardless of where they lived. Beneficiaries would pay, on average, 12 percent of the premium for the package of benefits. The government would be negotiating to minimize the cost to itself of the other 88%. Those who chose plans that cost more than average would pay the extra cost themselves; those who chose plans that cost the average would pay 12 percent and those who chose plans that cost substantially less than the average would pay nothing out of pocket.

What are the advantages of a premium support program? Setting the government's contribution as a fixed percentage of the premium up to a specified dollar limit fundamentally changes the financial incentives associated with Medicare. Beneficiaries would have the incentive t choose an efficient plan and could choose the one that best satisfied their perceived needs.

The role of the government would be as important in the premium—support program as it is under the current program – but it would be a different role. In the traditional

Medicare system, the focus is on individual services and the levels of payment. With a premium—support program, the focus would be on setting the right price, deciding the appropriateness of the care, and determining whether the quality of care was adequate. Government would negotiate the prices of plans and the composition of the benefit packages, set its contribution, determine the rules for marketing and enrollment, and oversee the plans.

This is not a panacea however as there are a number of vexing problems to be addressed regardless of what changes do or do not happen to Medicare. These include risk adjustment, providing understandable and user—friendly information to beneficiaries, ensuring that high—quality care is being delivered, and providing safeguards for frail and vulnerable groups of beneficiaries. Flexibility would need to be given to the plans to allow them to respond to changes in the environment.

I believe that a move to this model will produce a more financially stable and viable Medicare program but it will not provide the long—term financing that is needed, particularly if an expanded benefits package is included in the new program. Estimates made by the Medicare Commission suggest that there would be moderate savings over a 10 year budget period compared to the projections of the present program. Congress would still be in the position of determining how to provide continued and additional long—term financing that would be necessary. However, some degree of cost control at the beneficiary level would have been achieved and appropriate attention to the quality of care would be part of the program.

Historically, any changes in the structure of Medicare or its reimbursement policy have been phased in over a period of several years. This has helped to cushion the disruption that abrupt change can cause. Phasing in changes makes sense. It would also be consistent with the strategy being followed by Social Security in slowly increasing the age of eligibility.

There is some concern about instituting substantial changes in a program that provides health care to the elderly. Many beneficiaries have had little experience with plans other than fee-for-service indemnity plans; many have low incomes, and some have little education. Congress would have to determine how these realities should affect reform, and whether some groups of beneficiaries should be exempt from any changes.

It is important that we establish now where we want to go with a reformed Medicare program and that we do so before we add yet more benefits to the program. Making these decisions when Medicare is not in a state of financial crisis will allow reform to occur uninfluenced by immediate budge pressures. Unfortunately, it will also make it harder for Congress to overhaul a popular program.

As we think ahead to the type of program that makes sense for the baby boomers as well as for the existing beneficiaries, it is important to keep in mind that the people who are now reaching 65 years of age have had very different experiences with health care from those of previous generations. Most have had health plans involving some form of

managed care, many have had at least some experience choosing among health plans, most have had more education than their parents and many will have a higher income and greater assets when they retire. The biggest change involves the women who will be turning 65 in the next decade. Most will have spent substantial periods in the labor force, many will have direct experience with employer-sponsored insurance and at least some will have their own pensions and income as they reach retirement age. All of this means that we need to think about future Medicare beneficiaries as a different generation, with different experiences, with potentially different health problems, and if we start soon, they will have different expectations.