The Effects of Merging Part A and Part B of Medicare

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Executive Summary

Introduction

Medicare’s two-part system continues to mirror the structure of private insurance at the time of Medicare’s inception in 1965, a structure that often included separate insurance for hospital and physician care. Part A covers certain costs for inpatient hospital and limited post-acute care services and is financed primarily by a 2.9 percent payroll tax on both employers and employees (1.45 percent each). Part B helps cover the costs of physician services, outpatient care, and other medical and post-acute services, and is financed through a combination of beneficiary premiums and federal general revenues. While the new Medicare Part C (more commonly known as “Medicare+Choice”) is financed using both Part A and Part B revenues and permits Medicare to contract with a variety of private health plans, the overwhelming majority of beneficiaries is still enrolled in original fee-for-service (FFS) Medicare where the differentiation between Part A and Part B is much more evident.

There is generally widespread agreement that FFS Medicare will require significant modifications so that it can better adapt to a changing health care environment as well as meet the needs of the baby boomers, the first of whom will reach age 65 in the year 2011. As part of this reform, some policymakers are considering merging Part A and Part B of Medicare.

Purpose

While there is increasing discussion about the desirability of merging Part A and Part B, few—if any—published sources identify or discuss the range of issues such a merger would pose. This paper attempts to fill this gap. Specifically, it was undertaken to provide historical context for the two-part structure, identify policy issues associated with unifying Medicare under a single system, and analyze the potential effects of a unified structure on the program and on beneficiary out-of-pocket costs.

Methodology

The authors reviewed published health policy literature, communicated with various Medicare program experts, and analyzed the potential effects of a unified structure on the Medicare program and on beneficiary out-of-pocket payments.

Background

Several analysts have identified areas in which Medicare’s two-part structure does not reflect the needs of the program or its beneficiaries in terms of its financing, cost-sharing structure, and capacity to coordinate payments for fee-for-service Medicare. One criticism is that Medicare’s separate financing systems make it difficult to adequately
finance the program over the long-term. It has been argued that the division between the financing sources of Part A and Part B restricts the government’s options in restructuring Medicare’s financing and in allocating revenues among different types of health care services. It has also been argued that the separate structure leads policymakers to focus on Part A solvency separate from Part B spending, rather than on beneficiary needs and program spending in its entirety.

A second criticism is that the current system has produced an inefficient cost-sharing structure. The extent of beneficiaries’ cost-sharing depends on whether the service they use falls under Part A or Part B. Currently, Medicare Part A has a high deductible and little coinsurance (except for hospital stays of longer than 60 days). Part B has a relatively low deductible with 20 percent coinsurance. Although a high Part A deductible was initially used to deter unneeded hospitalizations, it may not significantly affect utilization since beneficiaries generally are not the ones to determine whether they need hospital care. Moreover, as the Part B deductible has remained low over the years, it may not be successful at reducing the use of unnecessary Part B services. Additionally, Medicare has no catastrophic cap on beneficiary liability, and cost-sharing requirements are generally high relative to most private insurance policies. Furthermore, as a result of these shortcomings, many beneficiaries obtain supplemental insurance, which dampens the beneficial effects of the cost-sharing.

A third criticism is that the existence of two systems of financing for Part A and Part B has hindered management of original fee-for-service Medicare. In the 1960s, the Part A and Part B boundaries closely followed the way in which health care was delivered in the private sector, so payments for different components of care were more easily separable. Today, as the private sector continues to shift sites of care, payments for all services (inpatient and outpatient care alike) are coordinated. However, such payment coordination has not been possible in original fee-for-service Medicare. Supporters of integrating all of Medicare’s funding sources into one pool of money contend that it would enhance management of health resources and improve accountability for health spending in FFS Medicare.

Principal Findings

Merging Part A and Part B could have wide-ranging implications for the Medicare program. First, merging Part A and Part B could allow policymakers more flexibility in re-examining the current Medicare benefits package. Because of Medicare’s outdated cost-sharing requirements and lack of coverage for important benefits such as outpatient prescription drugs, most beneficiaries in FFS Medicare obtain some form of supplemental insurance to fill its gaps. If, for example, Medicare were to provide coverage for an outpatient prescription drug benefit under Part B in the current program, Part B’s costs would not be offset by any impact that drug coverage might potentially have on Part A costs (e.g., lower hospitalization rates for certain medical conditions). Similarly, if the benefit were provided under Part A, the HI Trust Fund would not realize any savings that
might accrue to Part B. Such potential problems would be avoided under a unified program.

Second, combining Part A and Part B would refocus the discussion of solvency and financing. Solvency typically refers to Part A, which is primarily funded by payroll taxes. (Technically, Part B is always solvent since, by definition, general revenues must make up any shortfall.) Merging Part A and Part B would require a new definition of Medicare solvency. Furthermore, if Parts A and B were combined, there could be increased pressure on the federal budget to use general revenues to pay some of the costs currently financed by the Part A Trust Fund, or it could result in greater pressure to lower Medicare expenditures. It could also mute the current “alarm clock” function of the Part A Trust Fund, which, in the past, has alerted Congress and the public when Medicare financing is insufficient to meet future needs. Alternatively, it could place beneficiaries at risk of paying a greater share of Medicare’s total costs through premiums and/or higher deductibles and copayments. Thus, policymakers would need to decide what part of future Medicare expenses would be financed by which financing sources.

Third, merging Part A and Part B creates potential benefits as well as potential problems in areas of program administration and Congressional oversight. Payment administration might be facilitated since Medicare would no longer have to contract separately for Part A and Part B claims processing, a bifurcated function that has been criticized as being inefficient and outdated. However, the Health Care Financing Administration (HCFA), the agency that administers Medicare, might have difficulty implementing program changes effectively, given its other current administrative burdens and limited resources. Additionally, jurisdictional disputes are likely to emerge in the House of Representatives if changes in the financing structure were proposed, since Medicare jurisdiction is shared in part by two House committees.

Finally, merging Part A and Part B would force consideration of the question whether Medicare is to be an entitlement or a voluntary insurance program. Assuming that beneficiary premiums would remain an element of Medicare financing, structuring Medicare enrollment as an entitlement would also require either making the mandatory premium or devising a method to exclude some services for beneficiaries who opt not to pay the premium. Each of these options presents its own set of problems.

Besides affecting Medicare operations, combining Part A and Part B could also affect beneficiaries’ payments to Medicare to the extent that deductible levels and coinsurance are changed. The impacts depend on how cost-sharing is modified—for example, whether the deductible is high or low, whether separate deductibles are maintained for inpatient and outpatient care services; whether coinsurance levels are adjusted; whether catastrophic protection is offered; and whether supplemental insurance is allowed. A uniform deductible might make sense from a financial standpoint, although it would likely create winners and losers in a given year. As the Part A deductible has been relatively high and the Part B deductible relatively low, a unified deductible could be set at a level between the current Part A deductible ($768 per benefit period in 1999)
and the Part B deductible ($100 per year in 1999). Such a deductible structure would leave current Part A users (roughly 20 percent of beneficiaries) better off and, in general, those who use only Part B services (roughly 65 percent of beneficiaries) paying more out-of-pocket than under the current system.

Conclusions

Medicare, widely considered to have been successful in improving access to care and lessening the financial burdens of health care for older Americans, is also viewed as a program in need of a more updated management structure. The two-part system that drives many of its payment and revenue policies almost certainly would not be adopted if the program were being redesigned today. The current design reflects some factors that, while relevant when Medicare was initiated in 1965, are now not pertinent.

If Medicare Part A and Part B were merged, it likely would be part of more wide-scale changes to the program. Regardless of the magnitude of changes enacted, creating a more unified structure would be consistent with aligning Medicare with changes in health insurance that have occurred since the program’s creation. Indeed, combining Part A and Part B may be necessary to offer FFS Medicare more flexibility to adapt to a continually changing health care environment. Nonetheless, the impacts of combining Part A and Part B would depend on the particular changes involved. Thus, proposals to merge Part A and Part B, either alone or as part of broader changes to Medicare, would need to be carefully scrutinized to assess the net impact on beneficiaries, on Medicare’s financing sources, and on implications for the program’s long term stability.
The Effects of Merging Part A and Part B of Medicare

I. Introduction

Medicare, the federal health insurance program for over 33 million persons aged 65 and older and 5 million persons with disabilities, has had two parts since its inception in the mid-1960s. To a large extent, this system mirrors the structure of private insurance at the time of Medicare’s inception in 1965, a structure that often included separate insurance for hospital and physician care. Under the original fee-for-service (FFS) Medicare system, Part A (Hospital Insurance or HI) covers certain costs for inpatient hospital and limited post-acute care services and is financed primarily by a 2.9 percent payroll tax on both employers and employees (1.45 percent each). Part B (Supplementary Medical Insurance or SMI) helps cover the costs of physician services, outpatient care, and other medical and post-acute services, and is financed through a combination of beneficiary premiums and federal general revenues. Indeed, Part A and Part B continue to be separately financed programs with separate delivery responsibility for fee-for-service Medicare. While the Balanced Budget Act of 1997 (BBA) created a new Part C (“Medicare+Choice”) that is financed using both Part A and Part B revenues and permits Medicare to contract with a variety of private health plans, the majority of beneficiaries is projected to be enrolled in FFS Medicare for the foreseeable future.1

The problems of the current Medicare system—its costs, its limits in coverage, the demands that will be placed on it by the large baby boom generation, and its limitations in adapting to a changing health care environment—have been well documented. Even though changes made in the BBA are projected to extend solvency of the Part A Trust Fund until 2008,2 Medicare will most likely require significant modifications in order to contend with the eligibility of the baby boomers, the first of whom will reach age 65 in the year 2011.3 The BBA established the National Bipartisan Commission on the Future of Medicare to recommend what Medicare should look like in the 21st Century. Fundamentally, the Commission is assessing whether the current structure, which was created when Medicare began more than 30 years ago, is still appropriate in today’s budgetary and health care environment.

Some policymakers and policy analysts are considering restructuring Medicare from a two-part system (Part A and Part B) to a single structure. This idea has been proposed in the past, discussed in the context of some long-term restructuring proposals in the last few years,4 and is being considered by the Medicare Commission in the current debate on Medicare. Potential advantages for combining Part A and Part B of Medicare include the following:

1 CBO (1997).
2 Board of Trustees, Federal Hospital Insurance Trust Fund (1998)
3 Some baby boomers with disabilities are already in the program.
• **Merging Part A and Part B would modernize Medicare, as its current two-part structure has become less relevant with the passage of time.** The separation of Medicare into Part A and Part B is based on several compromises made when the program was originally formed in the mid-1960s. The two-part structure also reflects an insurance structure that existed at that time, when, unlike today, separate policies for hospitals and physician services were commonplace. Today, the division of services among Parts A and B is frequently arbitrary (e.g., home health care) and has shifted over time.

• **Merging Part A and Part B allows Congress (and Medicare) more flexibility in the program by creating more financing options.** Part A depends primarily on workers' contributions (i.e., the payroll tax) to finance beneficiaries’ hospital benefits,\(^5\) while Part B is financed by beneficiary premiums and general revenues. Some argue that the division between the financing sources restricts the government’s options in restructuring Medicare’s financing and in allocating revenues among different types of health care services. It can also be argued that the separate structures lead policymakers to focus separately on the issues of financing Part A and Part B, rather than on the program as a whole.

• **Merging Part A and Part B could lead to administrative improvements.** Combining Part A and Part B would allow Medicare to modify its claims processing system, which relies on private sector fiscal intermediaries to process Part A claims and carriers to process Part B claims. This structure has been criticized for being excessively cumbersome and no longer reflecting the existing health insurance system. Furthermore, merging Part A and Part B could reduce confusion by beneficiaries and the general public, many of whom do not understand the distinction.

• **Combining Part A and Part B facilitates modification of Medicare’s current cost-sharing structure.** Merging Part A and Part B could allow policymakers to more easily modify the existing deductible structure. Part A currently has a relatively high deductible that is paid each time a beneficiary is admitted to the hospital following a “spell of illness,”\(^6\) while Part B has a relatively low annual deductible. Such a two-part deductible structure is unusual in the private sector. Merging Part A and Part B could also facilitate the implementation of a catastrophic stop-loss, which would cap a beneficiary’s cost-sharing liability for the year, as is done in the majority of private sector plans. Such a measure, while passed and repealed in the 1980s, has been advocated again by some policy analysts.

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\(^5\) Indeed, current workers are financing their parents’ and grandparents’ Part A costs. These workers are future beneficiaries, whose Part A costs largely will be financed by payroll tax contributions from their children and grandchildren.

\(^6\) If a beneficiary re-enters a hospital within 60 days following a discharge from a hospital or skilled nursing facility, he or she will not have to pay the Part A deductible again. However, a beneficiary re-entering a hospital after more than 60 days following a discharge will need to pay the Part A deductible once more.
Merging Part A and Part B could lead to improved management of fee-for-service (FFS) Medicare. Merging Part A and Part B might facilitate Medicare’s ability to move toward greater integration of payments in its FFS program. (Medicare Part C—Medicare+Choice—already integrates payments.) Some analysts have argued that combining Part A and Part B might allow Congress and the Administration to design payment policies that enhance management of health resources, improve accountability for total health spending, and modernize contracting for services by focusing on the entire delivery system, rather than on a particular setting (e.g., hospitals or physician offices). For example, Medicare’s efforts to pay for disease management might be facilitated through coordination of payments from one pool of money.

While a merger of Part A and Part B might be considered as part of a stand-alone proposal, such a merger could accompany other restructuring proposals that are currently being considered. Moreover, a modified fee-for-service structure could potentially operate more efficiently as a health plan without having the arbitrary distinction between Part A and Part B services. Furthermore, those proposing to alter or enhance Medicare’s benefit package, its financing, or its cost-sharing structure would not have to determine how to shift funds or services between Part A and Part B.

While there are a number of potential advantages to a merger, combining Medicare Part A and Part B poses some potential problems, as well. Among the problems associated with merging Part A and Part B are the following:

- **Merging Part A and Part B of Medicare would require difficult decisions about how or whether to combine Part A’s “entitlement” with Part B’s voluntary enrollment.** Currently, upon reaching age 65, virtually all Americans automatically are enrolled in Part A by virtue of having paid the Hospital Insurance payroll tax during their working years. No Part A premium payments are required for those age 65 and older (or for those who qualify for Medicare at a younger age as a result of being disabled). In contrast, enrollment in Part B is voluntary and requires premium payments. Combining Medicare Part A and Part B requires deciding whether a combined Medicare program would be structured such that beneficiary premiums would no longer be voluntary, or, if they were voluntary, how to limit benefits for those who did not pay premiums. If the program became voluntary, then some who paid into the system during their working years might lose their “entitlement” if they did not—or could not—pay the premium. Such decisions could affect both access to care and public support for Medicare.

- **The current structure provides some fiscal constraint while, to some extent, limiting beneficiary exposure.** Medicare Part A payments must come from the
HI Trust Fund, which is financed primarily by payroll taxes. Moreover, beneficiaries do not generally pay a Part A premium. This financing structure provides some fiscal discipline because the federal government does not use general revenues to finance the HI Trust Fund (except for some revenue from the taxation of Social Security benefits). However, if Part A and Part B were combined, there could be increased pressure either to use general revenues to pay some of the costs currently financed by payroll taxes, or to place beneficiaries at risk of paying a greater share of Medicare’s total costs through premiums.

• **The “alarm clock” function of the Part A Trust Fund could be muted if Part A and Part B were combined.** Currently, the Part A Trust Fund functions as an alarm that alerts Congress and the general public to impending shortfalls. If Part A and Part B were combined into one Trust Fund, there might be a weaker or delayed signal that the program lacked sufficient future financing.

• **There are other potential political and administrative difficulties in implementing a merged Part A and Part B structure.** Jurisdictional disputes would likely emerge in the House of Representatives if changes in the financing structure were proposed, since Part A and Part B fall under the jurisdiction of different committees. Also, the Health Care Financing Administration (HCFA) may have difficulty implementing program changes effectively, given its other current administrative burdens, such as implementing Medicare+Choice, if it is not provided with sufficient resources and flexibility.

• **Combining Part A and Part B might adversely affect enrollees currently in Part A only.** Some beneficiaries currently enrolled in Part A have not needed to enroll in Part B because they already have comparable insurance. These individuals include retirees of the Federal Employees Health Benefits Program (FEHBP) and those who receive coverage from an employer. If Part A and Part B were merged, then these beneficiaries would either have to pay a premium for duplicative coverage or their coverage would have to be altered.

While the idea of combining Part A and Part B is not new, there has been very little literature that specifically analyzes this topic. Most of the analysts examining this issue have suggested that a merger of Part A and Part B would accompany broader Medicare reforms; however, these analysts tend not to examine the implications of combining Part A and Part B *per se*. This paper attempts to fill this analytical void by

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7 In 1997, payroll taxes accounted for about 88 percent of the HI Trust Fund’s income. Additional sources of income include taxation of a portion of Social Security benefits, interest on federal securities, and premiums paid by voluntary enrollees (Board of Trustees, Federal Hospital Insurance Trust Fund, 1998).

8 Some persons age 65 and older who do not meet the Social Security Act’s standard requirements for Part A may receive benefits by paying a monthly premium. Individuals qualify for Medicare Part A if they or their spouse paid into the Social Security (or Railroad Retirement) system for at least 40 quarters.

9 The Ways and Means Committee has exclusive jurisdiction over Part A, and shares equally with the Commerce Committee jurisdiction over Part B, as well as issues that affect both Part A and Part B.

10 See, for example, Aaron and Reischauer (1995), Dowd, Feldman, and Christianson (1996).
providing a more comprehensive analysis of the issues relating to merging Part A and Part B of Medicare. The paper first provides a brief history of Medicare’s initial separation into two components, describes program financing, and discusses problems with the current two-part structure. Second, it assesses the potential effects of merging Part A and Part B on the Medicare program (i.e., the benefits package, Trust Fund solvency, Congressional oversight, program administration, and Medicare enrollment issues). Third, it illustrates the potential effects on beneficiaries (i.e., deductibles, coinsurance, and beneficiary premiums) using a simple numerical example. In conclusion, the paper discusses policy implications of merging Part A and Part B of Medicare.

II. Background

Medicare, first established through the Social Security Amendments of 1965, was implemented on July 1, 1966. According to Lave (1988), the program’s main goals were to:

1) lessen the financial burdens of health care coverage on older persons; and
2) increase access to health care for persons age 65 and over.

In 1972, the program expanded eligibility to persons receiving Social Security disability payments and others with end-stage renal disease (ESRD).

Medicare’s passage came about after a long period of extensive public debate. Its origin can be traced to the national health insurance system proposed in the late 1940s by President Harry Truman (Moon, 1996; Marmor, 1973). Although no such legislation was enacted during his presidency, his efforts sparked continued discussion. The debate later focused on ensuring coverage for individuals age 65 and older, a vulnerable subgroup of the population. Nearly a decade before its actual implementation, Medicare was proposed as an insurance program for this subgroup. Growing hospital costs and limited health insurance for older persons increased support for such an insurance program. In 1963, only 56 percent of individuals age 65 and older had hospital insurance (Gornick, 1996). At first, despite support from the public and President John F. Kennedy, Medicare fell short of votes in Congress. After the elections of 1964, President Lyndon Johnson and Congress gave passage of Medicare legislation high priority (Starr, 1982).

The concept of separating Medicare hospital insurance from physician care coverage came, in part, from the desire of those drafting Medicare legislation to design a program that would be difficult for opponents to attack. Specifically, Medicare’s original strategists decided to focus on hospital insurance financed through a traditional social insurance payroll tax. They excluded physician services from their bill so that any opposition by physician groups such as the American Medical Association (AMA)—one of its staunchest critics—would have less standing. The strategists felt that a hospital insurance program for older Americans would still protect the elderly population (many
of whom were uninsured) from the unpredictable high costs of a major illness generally associated with a hospital stay (Ball, 1995).

During the ensuing debates, however, several alternatives were proposed to this structure. Many liberals and conservatives envisioned Medicare to be more comprehensive than a hospital insurance program (Moon, 1996). Additionally, polls conducted by the AMA found that the public wanted Medicare to cover physicians’ services as well as hospital services (Starr, 1982). Some Congressional opponents preferred a voluntary expansion of the private market rather than enacting a new “social insurance” program. In the end, Wilbur Mills, then chairman of the House Ways and Means Committee, constructed a “compromise” final package that expanded Medicare beyond hospital insurance (Moon, 1996). In addition to hospital insurance financed through a payroll tax, the compromise included a voluntary supplementary medical insurance program, which was designed to primarily cover physician services, and would be financed through general revenues and beneficiary premiums. The hospital insurance program became known as Medicare Part A, while the voluntary insurance for physician services became known as Part B of Medicare.11 President Johnson signed Medicare into law on July 30, 1965. The program was implemented the next year.

Medicare’s hospital insurance (Part A) was structured as an entitlement program in which individuals contributed to the system during their working years and received Part A benefits when they reached age 65. The design of Medicare Part A was closely tied to another federal social insurance program, Old Age and Survivors Insurance (OASI), which provided monthly benefits to retirees who contributed to OASI during their working years, their dependents, and their survivors. An individual was eligible for Medicare Part A if he or she was eligible for monthly Social Security retirement benefits, Social Security survivor benefits, or railroad retirement benefits. In 1972, Medicare was expanded to include disabled workers below age 65 covered under Social Security disability insurance (SSDI). In later years, certain federal, state, and local government employees (who were not covered under Social Security) became eligible for coverage and could contribute to the program (CCH Incorporated, 1997). As with OASI and SSDI (together known as OASDI), Medicare Part A was to be financed almost entirely by payroll taxes, with contributions made to a separate trust fund (Gornick, 1996).12

Medicare’s supplementary medical insurance (Part B) was structured as a federally subsidized insurance program. Sponsored by the federal government, its benefits were prescribed by law, and participation in Part B required payment of a monthly premium (unlike Part A of Medicare). The program’s design did not include

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11 Additionally, the compromise legislation instituted a new program—Medicaid—that expanded state funding for medical care for persons with low income.

12 Annual revenues from payroll tax contributions are made to the HI Trust Fund. Medicare Part A expenditures are paid out of the Trust Fund balance. In FY 1997, the HI Trust Fund received $128.5 billion in revenues, of which $112.7 billion came from payroll tax revenues and $15.8 billion came from interest on federal securities, taxation of Social Security benefits, and other sources (Board of Trustees, Federal Hospital Insurance Trust Fund, 1998).
compulsory participation in Social Security during the working years, and participation was made voluntary (Gornick, 1996). Thus, only those individuals who paid the premium would receive Part B benefits.

The Part A and Part B benefit package and design, as well as provider reimbursement strategies, also reflected the existing private health insurance system. In the 1960s, separate hospital and physician insurance plans were commonplace in the private sector. (For example, Blue Cross hospital insurance was then sold separately from Blue Shield physician care coverage.) The goal of the hospital insurance entitlement was to assure that those aged 65 and older received the same level of care as did other insured patients. As a result, the Part A benefit package and hospital reimbursement strategy were modeled closely after Blue Cross, which had a dominant presence in the hospital insurance market at the time. Part B, by contrast, was based on a private insurance plan, Aetna, then popular among Federal Employees Health Benefits Program (FEHBP) enrollees (Ball, 1995).

For the most part, the basic Medicare benefit package (Part A and Part B) has changed little since the program’s inception (Moon, 1996). Today, the Part A benefits include:

⇒ inpatient hospital care (up to 90 days per benefit period plus 60 lifetime reserve days);
⇒ inpatient psychiatric care (190 day lifetime limit in psychiatric hospitals);
⇒ skilled nursing facility care (following a three-day hospital stay);
⇒ up to 100 home health visits that follow a three-day hospital stay; and
⇒ hospice care.

Part B benefits include:

⇒ physician services (visits, surgeries, and consultations);
⇒ laboratory and other diagnostic tests;
⇒ outpatient services;
⇒ some mental health services;
⇒ durable medical equipment;
⇒ coverage of some preventive services; and
⇒ home health visits that do not follow a hospital stay and those visits beyond the 100 visits following a three-day hospital stay (CRS, 1997).13

Although Medicare’s benefit package is generous in some respects, neither Medicare Part A nor Part B covers such benefits as:

⇒ outpatient prescription drugs;
⇒ dental care;

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13 Between July 1981 and December 1997, home health care agency services were almost exclusively provided by Part A of Medicare (Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, 1998). Prior to July 1981, the home health benefit was split between Part A and Part B (CCH Incorporated, 1981).
⇒ vision services; and
⇒ long-term care.

In addition, there is no cap on annual cost-sharing, unlike many private sector insurance policies.

Much of Medicare’s general administrative structure has also persisted over time. HCFA contracts with private entities for assistance with the administration of the fee-for-service portion of the Medicare program. These Medicare contractors, usually health insurance companies, are known as fiscal intermediaries and carriers. Fiscal intermediaries primarily process bills and make payments for Part A services billed by a facility, such as hospitals or skilled nursing facilities. Carriers primarily process claims and make payments for all Part B services billed by a physician or supplier. In addition to processing claims, fiscal intermediaries’ and carriers’ contractual responsibilities include reviewing claims to make coverage determinations, determining the appropriate level of payment, and deterring and detecting fraud and abuse. In January 1996, HCFA contracted with 43 fiscal intermediaries and 28 carriers (HCFA, 1996).  

III. How Medicare Is Financed

Jointly, revenues for Medicare Part A and Part B were $209 billion in 1997, including $112.7 billion in payroll taxes, $19.1 billion in beneficiary Part B premiums, $59.5 billion in general revenue contributions to Part B, and about $18 billion in interest on federal securities, taxation of a portion of Social Security income, and other income (see Figure 1). Outlays were $210 billion, with Part B benefits just over one-half as large as Part A benefits (see Figure 2). This ratio will change over the next several years, as outlays for many home health benefits—about $17.1 billion by 2004—will be shifted from Medicare Part A to Part B (CBO, 1998).

Currently, the financing and outlays for Part A and Part B are separate. In order to understand the implications of combining Part A and Part B of Medicare, however, it is important to understand how each is currently financed. This section provides a more detailed discussion of the current financial structure of Medicare Part A and Part B.

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14 In 1996, 38 of the fiscal intermediaries and 20 of the carriers were Blue Cross/Blue Shield companies.
Financing of Part A

The structure of financing for Part A was modeled after OASDI, whose primary funding mechanism was and continues to be the payroll tax. Taxes are contributed by current employees and employers. Revenues are earmarked for the HI Trust Fund and pay for Part A services that current Medicare beneficiaries receive (Gornick, 1996). The rationale for this “pay-as-you-go” strategy was that people would pay into the system while working in order to earn protection for their hospital insurance coverage without having to pay a premium for that insurance upon retirement. Supporters contended that such a strategy was highly successful with Social Security (Ball, 1995). As with Social
Security, hospital insurance, in the view of its supporters, became an “earned right, that is, based on past earnings and contributions” (Ball, 1995, p. 66).15

The payroll tax dedicated to HI was implemented in 1966. At that time, an additional payroll tax (i.e., beyond that paid for Social Security) of 0.35 percent each was assessed on employers and employees16 in order to generate revenue for the HI Trust Fund. As with Social Security, taxes were computed on a person’s annual earnings up to a maximum annual amount (the “maximum tax base”), which was originally set at $6,600 (Board of Trustees, Hospital Insurance Trust Fund, 1998). Since that time, both the employer/employee rates and the maximum tax base have risen a number of times. Between 1966 and 1986, the tax rates increased gradually from 0.35 percent to their current level of 1.45 percent each on employees and employers (or 2.9 percent total). In 1986, the maximum tax base was at $42,000. In subsequent years, although the payroll tax remained at 2.9 percent total, the maximum tax base continued to be the same as that for OASDI until 1991, when the HI’s maximum tax base was increased from $51,000 to $125,000. This maximum amount of taxable earnings for the HI program increased each year, until, in 1994, it was removed altogether (although a maximum tax base for OASDI has remained17).

Today, Medicare Part A is financed primarily by this 2.9 percent tax on payroll, or 1.45 percent each from employers and employees. In 1997, payroll taxes accounted for about 88 percent of the HI Trust Fund’s income. The second largest source of income for Part A was interest income on federal Treasury securities held as assets by the Trust Fund. The next largest source of trust fund income came from the taxation of a portion of Social Security benefits.18 Other income to the Trust Fund came from premiums paid by voluntary enrollees and other sources (Board of Trustees, Hospital Insurance Trust Fund, 1998; see Figure 1). By law, Part A payments can be made only if there is a positive HI Trust Fund balance (Moon, 1996).

15 People earn the right to participate in Part A by past earnings and contributions. However, this does not mean that their contributions give them an accrued property or contractual right to receive benefits in the future. See Flemming v. Nestor, 363 U.S. 603, 611 (1960) (Congress can alter, amend, or repeal any provision of the Social Security Act, citing 42 U.S.C. sec. 1304). Workers’ contributions do not finance the future benefits they receive. Current workers pay the large majority of costs for current Medicare recipients.

16 The self-employed initially paid just the employer’s share; this rule was later changed so that they would pay the combined employer-employee percentage.

17 The OASDI base continues to increase automatically each year with increases in the average wage index (U.S. House of Representatives, 1996, Table 1-31).

18 Since 1993, a portion of Social Security income has been subject to taxation, with revenues directed to the HI Trust Fund. Since there is no upper income limit on this taxation, this tax added an income-related component to Part A financing.
Financing of Part B

Unlike Part A, Part B was designed to be financed through a combination of beneficiary premiums\(^\text{19}\) and a federal contribution financed through federal general revenues. As participation in Part B was to be voluntary, beneficiaries were required to pay a premium to participate. However, the government subsidy was an unavoidable result of the program’s voluntary nature. Without such a subsidy, uniform beneficiary premiums, based on the average cost of all participants, would not have been attractive to younger and healthier beneficiaries (Ball, 1995), and the program would have experienced adverse selection. Moreover, high premiums would have placed a large financial burden on lower-income beneficiaries.

Part B’s financing has also changed a number of times since the program’s inception. When the program was first implemented in 1966, the Part B monthly premium was set to cover half of the program’s costs,\(^\text{20}\) with the remaining 50 percent to be financed by federal general revenues. In the years immediately following Medicare’s enactment, policymakers maintained the monthly premium at 50 percent of the program’s costs. As a result, because of the rapid increase in Part B costs, beneficiary premiums began to escalate rapidly as well.

In 1972, policymakers enacted legislation to slow the growth of beneficiary Part B premiums. Due to high general price inflation and rising health care costs, premium increases were outpacing increases in Social Security benefits. The 1972 legislation limited the annual percentage increase in premiums to the same percentage as the cost-of-living adjustment (COLA) used to increase Social Security benefits. With this change, revenue from beneficiary premiums soon began to cover less than 50 percent of Part B costs, since health care and program costs were growing much faster than Social Security payments. Because Medicare costs continued to outpace the COLAs, the share of Part B costs paid by premiums decreased each year.

In the early 1980s, Congress enacted legislation to freeze beneficiary premiums at 25 percent of Part B costs. This law was modified slightly under the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), which set specific premium amounts for 1991 through 1995, using Congressional Budget Office (CBO) projections of what 25 percent of Part B costs would be over that time period.\(^\text{21}\) Subsequently, the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) continued setting premiums at 25 percent of Part B costs for 1996 through 1998, but again as a percentage instead of a fixed dollar amount (as before OBRA 1990). Annual premium increases were scheduled to again be tied to COLA increases beginning in 1999 (U.S. House of Representatives, 1996).

\(^{19}\) The monthly premium is $45.50 in 1999.

\(^{20}\) Policymakers chose to set a uniform premium for all individuals age 65 or older, rather than allow premiums to vary by age. If premiums varied with age, the rates for an 80-year-old, for example, would have been prohibitive for most beneficiaries (Ball, 1995).

\(^{21}\) The 1995 premium, however, covered about 31.5 percent of Part B costs, because the actual program costs increased at a slower rate than the CBO had projected between 1994 and 1995.
However, the BBA modified beneficiary premiums to continue covering 25 percent of program costs (rather than being tied to COLA increases) beyond 1998 (BBA, 1997).22

There is a trust fund for Part B—the SMI Trust Fund. However, this trust fund does not face the same financial problems as the HI Trust Fund because the U.S. Treasury is required to make up the difference between Part B spending and premium contributions (Moon, 1996).

IV. Criticisms of Medicare’s Current Two-Part Structure

Analysts have identified a number of ways in which Medicare’s current two-part structure does not reflect the current needs of the program or its beneficiaries. Among the areas they have identified are Medicare’s financing, cost-sharing structure, and capacity to move toward greater integration of care. Explanations of their criticisms follow.

• The separate financing systems restrict the options for adequately financing the program over the long-term.

It has been argued that the division between the financing sources of Part A and Part B restricts the government’s options in restructuring Medicare’s financing, particularly in allocating revenues among different types of health care services. It can also be argued that the separate structure leads policymakers to focus on the issues of financing Part A and Part B separately, rather than on the program as a whole. Observers have also argued that there is no strong policy reason to finance Part A benefits (i.e., inpatient hospital care and other post-acute services) by payroll taxes, and Part B benefits (i.e., outpatient services) by premiums and general revenues (Davis, 1997).

In recent years, policymakers’ primary focus has been on the solvency of the Part A Trust Fund. Most observers agree that, over the long term, the payroll tax is an insufficient financing source for covering hospital and other post-acute care covered under Part A of Medicare. There are several reasons why a proportional payroll tax is not expected to generate enough revenue over time for a retiree health insurance program. First, the number of persons age 65 and older is growing faster than the number of workers. Today, there are almost four workers paying taxes to support each beneficiary. However, by 2010 (the year before the baby boomers begin to collect benefits), the figure will have dropped to about 3.6 workers per beneficiary. Moreover, by 2030, there will only be 2.3 workers supporting each beneficiary (Board of Trustees, Hospital Insurance Trust Fund, 1998).23 Second, Part A expenditures are growing faster than productivity.

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22 Although beneficiary premiums grew at a faster rate than the COLA, a provision in law, known as “hold harmless,” prohibits Social Security checks from falling below the dollar amount of the previous year due to increases in the Part B premium.

23 These declining ratios do not necessarily indicate a dramatic increase in the financial burden for the working age population. Another measure of the financial burden on the working population is the worker
gains in the economy. Health care costs in general have historically grown faster than wages (Davis, 1997), and Medicare costs have also been rising faster than its wage base. Between 1992 and 1997, wages and salaries increased at an average annual rate of just over 3 percent. However, during that same time period, total Part A Medicare spending (including administrative costs) grew at an average annual rate of 10.4 percent. While the BBA achieved Medicare savings by slowing the growth in Part A spending (CRS, 1997), the increases are still expected to exceed the rate of growth in wages.

Part of the reason that the BBA achieved Part A savings was that certain home health costs were transferred from Part A to Part B of Medicare. However, as a consequence of the BBA, Part B costs are now expected to grow faster than they would have in the absence of any legislation (Board of Trustees, Supplemental Medical Insurance Trust Fund, 1998). Beneficiaries will bear some (about 25 percent) of these costs as higher Part B premiums. The transfer of some home health spending from Part A to Part B was done to help address Part A solvency concerns, rather than as a policy change intended to affect home health care costs.

- **The current system has produced an inefficient cost-sharing structure.**

Medicare’s structure does not follow the structure of the “optimum” insurance package espoused by some health policy analysts. In their view, the optimum insurance model contains three key features (Lave, 1988):

- a deductible structure that decreases the administrative costs of processing a high number of small claims;
- a catastrophic cap on beneficiary liability; and
- coinsurance that is designed to reduce moral hazard, i.e., insurance-induced demand. (Deductibles also reduce moral hazard.)

Currently, Medicare has an unusual and complex cost-sharing structure. Part A has a relatively high deductible per benefit period ($768 in 1999) as well as substantial coinsurance charges for certain Part A services. Part B has a relatively low deductible

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24 The figure is based on AARP Public Policy Institute’s calculations using Employment Cost Index (ECI) data from the Bureau of Labor Statistics, Office of Compensation Levels and Trends. The ECI used is seasonally adjusted and based on wages and salaries for private industry workers. Values are as of December of each year.

25 The figures are based on AARP Public Policy Institute’s calculations from data in the Annual Report of the Board of Trustees, Federal Hospital Insurance Trust Fund (1998).

26 For a more detailed discussion of the BBA measures, see CRS (1997).

27 Coinsurance is assessed on hospital stays after the 60th day of care in a benefit period. In 1999, this coinsurance is $192 per day for days 61-90, and $382 per additional day, up to a limit of 60 lifetime reserve
per year ($100 in 1999) and considerable (20 percent) coinsurance for most Part B services. The Part A deductible has been indexed over the years by the increase in hospital costs, while the Part B deductible is not indexed and has only been changed a few times in over 30 years. Although a high Part A deductible was initially used to deter unneeded hospitalizations, it may not significantly affect utilization today since beneficiaries generally are not the ones to determine whether they need hospital care. Moreover, as the Part B deductible has remained low over the years, it may not be successful at reducing the use of unnecessary health services. Additionally, Medicare has no catastrophic cap on beneficiary liability, and cost-sharing requirements are generally high relative to most private insurance policies. For these reasons, the Part A and B deductible structure may not be as effective as it could be at reducing over-utilization of health services.

It should be noted that the impact of a more optimal cost-sharing structure on reducing utilization may still be muted, since most beneficiaries in fee-for-service Medicare—over 80 percent in 1997—have some form of supplemental insurance (i.e., employer-sponsored supplemental insurance; beneficiary-paid Medigap; or Medicaid) that typically covers much of the cost-sharing (deductibles and copayments). The prominence of these supplemental insurance policies has resulted from the shortcomings of the current Medicare benefit package and cost-sharing structure. Some analysts have argued that these supplemental policies tend to increase the budget cost of Medicare by “short-circuiting” the economizing effects of cost-sharing and deductibles on administrative costs and the demand for services (Aaron and Reischauer, 1995). Indeed, supplemental coverage that provides first-dollar coverage can increase the utilization of either physician visits or hospital care. Using data from the Rand Health Insurance Experiment, Manning, et al. (1987) found that consumers with no coinsurance had nearly 37 percent more physician visits than those with 25 percent coinsurance. They also found that those with no coinsurance for hospital visits had almost 22 percent more inpatient admissions per capita than those with 25 percent coinsurance. A more rational cost-sharing structure could reduce the demand for supplemental coverage and enhance the impact of cost-sharing on unnecessary utilization. (It should also be noted that a cost-sharing structure that reduces utilization of unnecessary health care may also reduce the utilization of necessary health care, particularly for beneficiaries with limited income.)

- **The existence of two systems of financing for Part A and Part B has hindered management of Medicare fee-for-service (FFS).**

  Health maintenance organizations (HMOs) and other forms of managed care have increasingly adopted a level of coordination of payments for care that has not been
possible in original FFS Medicare. Supporters of integrating all of Medicare’s funding sources into one pool of money contend that it would enhance management of health resources, improve accountability for total health spending, and modernize contracting for services by focusing on the entire delivery system, rather than on a particular setting (e.g., hospitals or physician offices).

In the 1960s, when traditional fee-for-service insurance dominated the private insurance market, it was common for individuals to have two separate policies for hospitalization and physician services. Indeed, Part A and Part B had more clearly defined boundaries. Today, the division of services is sometimes arbitrary. For example, there is no strong policy reason why, from 1980 to the enactment of the BBA, home health care services had been paid primarily from Part A rather than Part B. (Similarly, the post-BBA allocation of home health services among Part A and Part B has no strong policy rationale.) Also, many services that used to be performed in a hospital inpatient setting (paid by Part A) are now performed in an outpatient setting (paid by Part B). Therefore, the line between care rendered during a hospital visit and that provided in an outpatient setting has become increasingly blurred (Aaron and Reischauer, 1995).

The separation of Part A and Part B has prevented the original FFS Medicare system from adopting economies applied in the rest of the health care system through integration of payments for all Medicare-covered services. The Medicare FFS system has operated as if inpatient hospital care, outpatient hospital care, physician services, and other components of care are easily separable into Part A services (with claims processed by fiscal intermediaries) and Part B services (with claims processed by carriers). Such lack of integration of payments makes it difficult for the original FFS Medicare program to integrate health care delivery and payment between its two parts—a restriction that does not exist for private sector insurance plans. For example, many efforts to pay for the disease management of high cost patients in FFS Medicare are potentially hindered because of the existence of two separate pools of money; currently, certain services are paid for by Part A while others are paid for by Part B. Paying for disease management could be facilitated through coordination of payments from one pool of money.

Unlike under FFS Medicare, there has already been a movement away from the two-part system in Medicare+Choice (i.e., Medicare Part C). Prior to the BBA, separate capitated payment rates were computed for Part A and Part B. However, Medicare+Choice (Part C) unifies the capitation payments, with financing based on predetermined proportions taken from the Part A Trust Fund and Part B Trust Fund. Medicare+Choice also requires enrollment in both Part A and Part B in order to

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29 According to HCFA (1998), about 15 percent of Medicare beneficiaries are currently enrolled in Medicare managed care plans (primarily HMOs). While the BBA expanded the type of managed care plans available to Medicare beneficiaries, the CBO projects that the majority of beneficiaries will be covered under the original FFS Medicare program in 2008 (CBO, 1998). As the formula for paying HMOs for each Medicare enrollee is currently a direct function of original FFS spending, inefficiencies in paying for Medicare FFS will also affect Medicare’s ability to save money if that enrollee joins a Medicare HMO.

30 See, for example, Budetti (1997).
participate, except for a small number of grandfathered enrollees. Unlike those in FFS Medicare, beneficiaries in these plans do not face separate cost-sharing requirements for Part A and Part B benefits. The challenges of implementing Medicare+Choice that providers, beneficiaries, and others are currently experiencing warrant further exploration to provide insight into factors that could be important when merging Part A and Part B.

V. Potential Effects of Merging Part A and Part B on the Medicare Program

Combining Medicare Part A and Part B could have wide-ranging implications for the Medicare program and its beneficiaries. The scope and magnitude of these effects would depend on the specific changes that occur when the programs are merged (i.e., changes in Medicare financing, the size of the combined deductible, the share of Medicare costs to be paid for by Medicare premiums, the extent to which supplemental policies can cover deductibles, and so forth). In addition, the potential effects would be influenced by whether the joining of Part A and Part B was accompanied by other major structural changes to Medicare.

The following discussion of the possible effects of merging Part A and Part B of Medicare is divided into two sections: Section V discusses the effects on the Medicare program, with discussion focusing on the benefit package, financing and Trust Fund solvency, Congressional oversight, program administration, and Medicare enrollment issues. Section VI provides an illustrative example of the effects on beneficiary out-of-pocket payments, with discussion focusing on deductibles, coinsurance, catastrophic stop-loss, and premiums (See Table 1).

**TABLE 1: Areas Potentially Affected by Merging Part A and Part B**

<table>
<thead>
<tr>
<th>EFFECTS ON:</th>
<th>AREAS POTENTIALLY AFFECTED</th>
</tr>
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| **Medicare Program** | • Benefits Package  
• Financing and Trust Fund Solvency  
• Congressional Oversight  
• Program Administration  
• Medicare Enrollment Issues |
| **Beneficiary Out-of-Pocket Payments** | • Deductibles and Coinsurance  
• Catastrophic Stop-Loss  
• Beneficiary Premiums |

**Benefits Package**

Combining Part A and Part B might provide an opportunity for policymakers to re-examine the current Medicare benefit package with an eye towards creating a more
modern, comprehensive package. Furthermore, it takes away the need to choose whether to provide particular benefits through Part A or Part B of Medicare.

Some observers contend that original FFS Medicare cannot be expected to compete with managed care unless it expands its benefits. The current Medicare package has at least several problems, including awkward cost-sharing requirements and lack of outpatient prescription drug coverage. Because Medicare offers less coverage than private insurance and managed care (CRS, 1996), most participants in original Medicare have some form of supplemental coverage (individually purchased insurance policies, employer-sponsored policies, or Medicaid).

Revising Medicare’s benefits package might be more administratively complex if the two parts continued to operate separately. If, for example, Medicare were to provide coverage for an outpatient prescription drug benefit under Part B in the current program, Part B’s costs would not be offset by any impact that drug coverage might potentially have on Part A costs (e.g., lower hospitalization rates for certain medical conditions). Similarly, if the benefit were provided under Part A, the HI Trust Fund would not realize any savings that might accrue to Part B.31 Such concerns would not exist under a unified program.

The ability to operate under a unified program has become more important as the private health care financing and delivery system becomes more integrated. The separation between hospital and physician care (and, for that matter, between acute and chronic care, or chronic care and long-term care) becomes more of an anachronism that does not reflect the system within which Medicare operates.

Financing and Trust Fund Solvency

Solvency typically refers to Medicare Part A, which is primarily funded by payroll taxes. Part B is always solvent, since by definition general revenues make up any financing shortfall. The Part A Trust Fund has historically had a positive balance; at the end of 1997, with a balance of $115.6 billion, its Trustees projected that, combined with future revenues, it had sufficient balance to finance outlays into the year 2008 (Board of Trustees, Hospital Insurance Trust Fund, 1998). The Part B Trust Fund has a relatively small balance, since each year’s outlays are funded from that year’s premium collections and general revenue contributions.

Merging Part A and Part B would require a new definition of Medicare solvency, since it would combine a self-financing program with one that, by definition, cannot become insolvent. Policymakers would be required to decide what part, if any, of future Medicare expenses would be financed by which financing sources. This would entail a

31 While there might be some cost savings due to reductions in other services (e.g., hospitalizations), adding a prescription drug benefit would be a costly expansion of Medicare. Many beneficiaries obtain prescription drug coverage through other sources even though Medicare does not pay for it.
re-assessment of the basic philosophy of the Medicare program. The concept of a self-financing HI Trust Fund emerged from Part A’s original design, with eligibility determined by whether a beneficiary had contributed during his or her working years. As noted earlier, the adequacy of payroll taxes as a mechanism for financing retiree health coverage becomes problematic when: (1) health care costs are rising faster than wages, and (2) the number of workers supporting each Medicare beneficiary’s costs is falling.

Among the options for policymakers to consider in designing a unified trust fund are:

- **Operating a new trust fund similarly to the current SMI Trust Fund, where current expenditures are largely financed by current revenues.**

  Under this option, Medicare revenues would have to be sufficient only to cover current year expenses. The notion of future solvency would no longer be linked to how far into the future Medicare would remain solvent, but rather to the amount of general revenues that would be required each year to make up the shortfall from other revenue sources. If projections of other revenues (e.g., payroll taxes and beneficiary premiums) were falling over time as a share of total program spending, thereby requiring a higher federal government contribution, then policymakers might consider revenue or benefit changes needed to adjust that imbalance.

  Adoption of this approach would raise the question of what to do with the current substantial HI Trust Fund balance. One option would be to maintain it in the unified trust fund, but to designate a portion of it each year to supplement other revenue contributions.32

  Adoption of such an approach would also mute the “alarm clock” function of the HI Trust Fund. The HI Trust Fund projections have, in effect, served as an “alarm clock” that alerts Congress and the public when Medicare financing is insufficient to meet future needs. The current structure is also backed up by requiring Congressional action to continue making payments should the Trust Fund run out of reserves. If the trust fund were designed solely to finance current revenues, the government might no longer face the pressures currently imposed on it to provide financing for the program’s future. Alternatively, the current “alarm clock” might be replaced by other markers of fiscal discipline, such as total federal spending on Medicare, Medicare spending as a percentage of the federal budget, and Medicare spending as a percentage of gross domestic product (GDP), although these indicators might not be as effective at promoting fiscal discipline.

  This design for a trust fund might also remove some of the current fiscal constraints of Medicare, since Part A spending would no longer be restricted to the HI Trust Fund balance. If policymakers could use federal general revenues to support Part A spending, some would argue that policymakers would lose the fiscal discipline provided

32 See, for example, Thorpe (1997).
by the trust fund. Alternatively, this design could make the program increasingly dependent on general revenues, which might weaken the entitlement status of Medicare Part A benefits.

- **Operating a new trust fund as a hybrid of the SMI and HI Trust Funds.**

  Alternatively, the trust fund could be operated in a way that maintains a substantial reserve, but that did not rely on this reserve to finance as much future spending as the current HI Trust Fund. One option would be to designate the shares of current outlays that would be financed by different sources—payroll tax revenues, beneficiary premiums, general revenues, and trust fund reserves. For example, beneficiary premiums could be designated to cover 12 percent of Medicare costs (the same share as they are projected to cover in 2007), and the federal government’s general revenue contribution could be set at its 2007 level of 35 percent of total Medicare costs. These ratios could be kept as a target over time or changed from year to year. One option is that the government’s contribution could be pegged to a given economic index (such as the growth in GDP, growth in health care costs, or other factors). This approach would also offer the Medicare program more flexibility to adjust to a changing health care delivery system, since particular revenue sources would no longer be tied to particular services or particular ways of delivering services.

  Under this approach, the federal government would have greater flexibility if it wanted to dedicate other tax revenues or premiums to Medicare. The federal government could also shift the relative burden of existing revenue sources (e.g., reducing the payroll tax and increasing federal general revenue contributions, or increasing premiums and reducing federal contributions), while avoiding the artificial constraints imposed under the current Part A/Part B system (i.e., that payroll taxes do not finance current Part B benefits, while general revenues and beneficiary contributions are not used to finance Part A benefits).

  Such an approach to designing a trust fund would be consistent with either a defined contribution Medicare program or the current defined benefit structure. Under a defined contribution, the government would provide a designated amount on behalf of each beneficiary to pay for various Medicare options (e.g., fee-for-service, HMOs, or other managed care plans). The size of the annual contribution could be directly related to the projections of trust fund balances. Under a defined benefit structure, insufficient

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33 See, for example, Fronstin and Copeland (1997).
34 Figures are based on AARP PPI analysis of the Board of Trustees, Federal Hospital Insurance Trust Fund (1998) and Board of Trustees, Supplemental Medical Insurance Trust Fund (1998).
35 Many observers contend that tying the growth of the federal contribution to Medicare to the growth in GDP could have an adverse impact on the Medicare program. It would tie spending to an index that has no relationship to society’s preferences for greater health care spending. Not only might Medicare spending grow faster than GDP because of a greater share of older Americans in the population, but because societies typically spend more on health care as they become richer. See, for example, Vladeck (1998).
36 If combining Part A and Part B were part of a restructuring that changes Medicare to a defined contribution program, it could provide greater predictability and control over spending. However, such
trust fund reserves would require action to either reduce the benefits covered under that structure or to raise revenues.

**Congressional Oversight**

Merging Part A and Part B would likely have important ramifications in the way that Congress oversees the Medicare program. Currently, Medicare falls under the jurisdiction of two committees in the House of Representatives. The Ways and Means Committee has exclusive jurisdiction over Part A, and shares with the Commerce Committee jurisdiction over Part B as well as issues that affect both Part A and Part B. (In the Senate, both Part A and Part B fall under the jurisdiction of the Finance Committee.) If Part A and Part B were combined, Congress would have to determine whether to continue this dual assignment, whether to reassign different components to particular committees, or whether to assign jurisdiction to a single committee.

**Program Administration**

Merging Part A and Part B raises substantial administrative issues. For example, it raises the question of whether, and how, to phase in a restructured program. Some of the administrative issues would be internal to HCFA—as well as its private sector contractors that administer the program—and would add to the administrative burdens HCFA already faces. HCFA would almost certainly need more resources, at least for the short term, to implement program changes promptly and effectively. Nonetheless, over the long term, merging Part A and Part B might lead to some administrative efficiencies that provide program savings.

An example of a benefit to program administration would be that HCFA would not have to contract with both fiscal intermediaries and carriers. In general, Part A is administered by *fiscal intermediaries*, while Part B is administered by *carriers*. Intermediaries and carriers are typically insurance companies that contract with the federal government to process, pay, and review Medicare claims as well as perform other operational and administrative tasks. However, with the increasingly blurred distinction between Part A and Part B services, having approximately 43 fiscal intermediaries and 28 carriers work independently may make the program more complex than if the tasks of intermediaries and carriers were not done by separate organizations. Additionally, as intermediaries and carriers currently handle beneficiary inquiries and appeals separately, merging Part A and Part B might clarify the process of filing appeals for beneficiaries. Moreover, as intermediaries and carriers currently send separate Medicare summary notices of benefits, a unified explanation of Medicare benefits indicating what Medicare limits could put beneficiaries at greater risk of paying for a growing share of program costs or receiving reduced benefits. In particular, once the government contribution is fixed, it might feel less pressure to take the kind of actions that reduce future Medicare costs, thereby increasing the cost to beneficiaries even more. See, for example, Moon (1996).
services were billed, which services were approved, and how much the beneficiary owed could potentially be potentially less confusing for beneficiaries. Merging Part A and Part B could facilitate federal antifraud efforts, not only by allowing beneficiaries to more easily detect errors, but also by making payment screens more effective, such as for identifying when Part B is billed for services that should have been bundled into a Part A hospitalization. Indeed, merging Part A and Part B could potentially reduce confusion by beneficiaries and the general public, many of whom do not understand the Part A/Part B distinction.

Medicare Enrollment Issues

Finally, combining Part A and Part B forces consideration of the question whether Medicare is to be an entitlement or a voluntary insurance program. Part A is an entitlement—all who paid into the system receive benefits, without additional payment, once they meet age or eligibility criteria. By contrast, Part B is voluntary and requires payment of a monthly premium. Under a unified system, it would be difficult to allow beneficiaries to decide to opt out of Part B, since there would be no distinct separation of Part B benefits. In 1997, about 5 percent of all Part A enrollees (or about 2 million people) opted out of Part B.37 Similarly, about 400,000 beneficiaries are enrolled in Part B but are not enrolled in Part A.38 Congress or HCFA would have to determine whether and how Medicare could be restructured to permit these “Part B only” individuals to receive medical care.

Assuming that beneficiary premiums would remain an element of Medicare financing, making Medicare an entitlement would also require either imposing a mandatory premium or devising a method to exclude some services for beneficiaries who opt not to pay that premium. A mandatory premium has at least two potential disadvantages—it might be viewed as a tax on Medicare beneficiaries,39 and it requires participation by those who may receive benefits elsewhere (e.g., through a current employer).40 However, if employers who offered coverage were required to pay toward the mandatory premium, they might attempt to drop their additional coverage. The

37 Authors’ calculations based on data from HCFA’s Office of Information Services. Quarterly counts are as of December 31, 1997. Most of those in Part A who have opted out of Part B are either: (1) beneficiaries who are still employed and covered under an employer’s health insurance policy and can join Part B without penalty at a later date; or (2) federal retirees who are enrolled in the Federal Employees Health Benefits Program (Aaron and Reischauer, 1995).
38 This figure is based on December 1997 HCFA estimates. Most of the Part B-only beneficiaries are retired teachers who were, and continue to be, not covered under Social Security. These beneficiaries receive Part A-equivalent coverage outside of Medicare.
39 There is a precedent for treating mandatory health insurance premiums as a tax. The CBO, in its assessment of the Health Security Act of 1994, treated mandatory health insurance premiums as revenues to the federal government (CBO, 1994).
40 Additionally, requiring all beneficiaries to purchase the equivalent of Part B benefits from a unified Medicare program could increase federal spending. The increase would occur because there would be a higher number of individuals for whom the federal government would need to pay the 75 percent share of Part B program costs.
alternative of exempting certain services for beneficiaries who opt out of the voluntary system might be impractical and counter to the advantages of merging Part A and Part B, given that a unified system might allow greater integration of services.

VI. Potential Effects on Beneficiary Out-of-Pocket Payments

Beneficiaries’ payments to Medicare would also be affected by the unification of Medicare Part A and Part B to the extent that deductible levels and coinsurance were changed. The particular impact depends on how cost-sharing might be modified—for example, whether the deductibles were high or low, whether or not separate deductibles were maintained for hospital and outpatient or ambulatory care services; and whether coinsurance levels were adjusted and catastrophic protection offered. This section provides an illustrative example of how beneficiaries might be affected by one specific cost-sharing structure under a unified Medicare system.

Assumptions

This example first assumes that financing for Part A and Part B is combined, so that all sources currently used to finance Medicare—primarily the current HI payroll tax, the current Part B beneficiary premium, and general revenue contributions—are put into a single trust fund. A second assumption for this analysis is that beneficiaries would face a single annual $250 deductible for Medicare services. This means beneficiaries would no longer pay separate deductibles for Part A services ($768 per benefit period in 1999) and for Part B ($100 per year since 1991). Additionally, this example assumes that the current coinsurance structure remains unchanged.

The choice of an annual $250 deductible reflects a rate that is comparable to many private insurance policies for the under-65 population. This would return the Medicare deductible closer to a private sector norm—a standard that was established when Medicare was first designed. Furthermore, a $250 deductible also could reasonably approximate the average deductible amounts currently paid by Medicare beneficiaries.

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Assumptions

This example first assumes that financing for Part A and Part B is combined, so that all sources currently used to finance Medicare—primarily the current HI payroll tax, the current Part B beneficiary premium, and general revenue contributions—are put into a single trust fund. A second assumption for this analysis is that beneficiaries would face a single annual $250 deductible for Medicare services. This means beneficiaries would no longer pay separate deductibles for Part A services ($768 per benefit period in 1999) and for Part B ($100 per year since 1991). Additionally, this example assumes that the current coinsurance structure remains unchanged.

The choice of an annual $250 deductible reflects a rate that is comparable to many private insurance policies for the under-65 population. This would return the Medicare deductible closer to a private sector norm—a standard that was established when Medicare was first designed. Furthermore, a $250 deductible also could reasonably approximate the average deductible amounts currently paid by Medicare beneficiaries.

\[ 64.3\% \times ($100) + 0.4\% \times ($768) + 20\% \times ($100 + $768) + 15.2\% \times ($0) = $241 \]

41 In a national survey of employer-sponsored health plans, the median annual deductible for private indemnity, preferred provider organizations, health maintenance organizations, and point-of-service plans tended to be $200-$250 (Mercer/Foster Higgins, 1997). Another survey found the average annual deductible for single coverage in a conventional indemnity insurance plan to be $228 (KPMG, 1997).

42 Using data from the 1995 Medicare Current Beneficiary Survey (MCBS), 64.3 percent of beneficiaries had one or more Part B claims only (and faced just the $100 Part B deductible), while 0.4 percent had Part A claims only (and faced just the Part A deductible). Another 20 percent of beneficiaries had both Part A and Part B claims (and faced both the Part A and Part B deductibles), while the remaining 15.2 percent had neither Part A nor Part B claims. Assuming 1995 utilization patterns and 1999 deductible levels, the average weighted deductible would be:
This single deductible could be totally or partially indexed to health care costs, as the current Part A deductible is today. (Policymakers would have to resolve the issue of whether, and how, to index any combined Part A and Part B deductible.)

A third assumption is that, over time, beneficiary premiums are set such that beneficiaries pay the equivalent share of currently projected premium liabilities. Currently, premiums are required to cover about 25 percent of Part B costs, or about 12 percent of total Medicare costs by 2007 (CBO, 1998). Under this assumption, beneficiaries would continue to pay the same share of total Medicare costs in premiums, although these funds would not be dedicated to what are currently Part B expenses. In this example, coinsurance and benefit package design are assumed to be unchanged.

The following example does not include potential effects of changes in the supplemental insurance market in response to the new deductible structure. Some of the issues that would need to be addressed include:

⇒ whether and how employers voluntarily alter their supplemental coverage so as to cover the single unified deductible;
⇒ whether beneficiaries continue to purchase Medigap coverage to insure against deductibles and coinsurance;44
⇒ whether and how Congress legislates Medigap policies to cover the new unified deductible (see text below for further discussion);45 and
⇒ whether Medicaid (and the Qualified Medicare Beneficiary or QMB) coverage would automatically pay the new unified deductible, and what would be the cost to state Medicaid programs.

**Impacts of Unified Deductible**

One of the most visible ways in which combining Part A and Part B would affect beneficiaries is in changing their deductibles and coinsurance for Medicare-covered services. As is illustrated in Table 2 below, such a unified deductible could transfer costs

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43 While most Part B users were exposed to Part B coinsurance in 1995, only about two percent of Part A users paid Part A coinsurance (AARP Public Policy Institute analysis of data from HCFA, 1997).

44 Changes in Medicare’s cost-sharing could have substantial effects on beneficiaries’ demand for Medigap policies.

45 Since 1992, Medigap insurance can only be sold in ten standard plans; nine plans cover the Part A deductible, and three of these plans also cover the Part B deductible. Some beneficiaries still have plans that were sold prior to 1992.
from beneficiaries requiring hospitalizations to those using only Part B services. Beneficiaries who require hospitalization would, by definition, pay lower deductibles, since their current $768 deductible would be capped at $250. However, those who used only Part B services would likely incur higher cost-sharing amounts if their utilization remained unchanged.

**TABLE 2: Examples of Potential Impacts of a Unified Deductible**

<table>
<thead>
<tr>
<th>Description of Beneficiary</th>
<th>Old Part A Deductible + Coinsurance</th>
<th>Old Part B Deductible + Coinsurance</th>
<th>Amount Paid Toward New Deductible</th>
<th>New Coinsurance</th>
<th>Impact in a Given Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospitalized and used $2,000 of approved Part B services</td>
<td>$768</td>
<td>Deductible: $100 Coinsurance: $380</td>
<td>$250</td>
<td>$400 (see footnote 47 in text)</td>
<td>old: $1,248 new: $650 BETTER OFF</td>
</tr>
<tr>
<td>2. Used $2,000 Part B only</td>
<td>$0</td>
<td>Deductible: $100 Coinsurance: $380</td>
<td>$250</td>
<td>$350</td>
<td>old: $480 new: $600 WORSE OFF</td>
</tr>
<tr>
<td>3. Used $200 Part B only</td>
<td>$0</td>
<td>Deductible: $100 Coinsurance: $20</td>
<td>$200</td>
<td>$0</td>
<td>old: $120 new: $200 WORSE OFF</td>
</tr>
<tr>
<td>4. Used $100 Part B only</td>
<td>$0</td>
<td>Deductible: $100 Coinsurance: $0</td>
<td>$100</td>
<td>$0</td>
<td>old: $100 new: $100 NO CHANGE</td>
</tr>
</tbody>
</table>

Table 2 illustrates the impact of the unified $250 deductible on four hypothetical beneficiaries. Note that this illustration assumes that utilization does not change and that the beneficiaries do not have supplemental health insurance coverage.46 First, Beneficiary #1, who is hospitalized (Part A) and also uses $2,000 in approved Part B services, incurs a lower cost-sharing liability with a $250 deductible. Under the current system, this beneficiary would pay the $768 Part A deductible, the $100 Part B deductible, and $380 in Part B coinsurance (20% of $1,900), or a total of $1,248. Under the unified deductible, this beneficiary would pay the $250 deductible and $400 in coinsurance,47 or $650 altogether. Thus, this beneficiary would be “better off” in terms of deductibles and coinsurance payments.

46 Most beneficiaries currently have some form of supplemental coverage that would absorb some or all of the changes in cost-sharing. While supplemental coverage reduces the direct impact of cost-sharing changes for most beneficiaries, beneficiaries would be affected indirectly by changes in premiums that occurred as a result of the higher or lower costs in their insurance pool. For the sake of our discussion, we refer to beneficiaries as being “better off” or “worse off” regardless of who ultimately pays the bill.

47 This assumes the beneficiary had been hospitalized prior to using physician services. If so, then he or she would have already satisfied the deductible. His or her coinsurance would then be 20 percent of the $2,000 physician approved charges, or $400. Conversely, if the beneficiary incurred the $250 deductible on physician services prior to being hospitalized, then his or her 20 percent coinsurance would be based on the remaining $1,750 for a payment of $350, or $600 altogether (i.e., $250 deductible + $350 coinsurance).
Conversely, most beneficiaries who only use Part B services would be “worse off” than under the current system. Under the current system, Beneficiary #2, who uses $2,000 in Part B services only, would pay the $100 Part B deductible and $380 in coinsurance (20% of $1,900), or $480 altogether. Under the unified deductible, this beneficiary would pay the $250 deductible and $350 in coinsurance, or $600 total. Therefore, Beneficiary #2 is “worse off” in terms of his or her cost-sharing responsibilities. Similarly, under the current system, Beneficiary #3, who uses $200 in Part B services only, would pay the $120 toward the Part B deductible and coinsurance; however, this beneficiary would need to pay the full $200 out-of-pocket if there were a $250 deductible. However, Beneficiary #4, who uses $100 in Part B services, would pay the same amount out-of-pocket ($100) under both the current and unified deductible scenarios.

The unified deductible might also shift some costs from the Medicare program to beneficiaries. Whether this would occur partially depends on whether the higher payments by those using only Part B services exceeds the reduced payments by those who use Part A services. In our example, we estimated that a $250 unified deductible is a reasonable approximation of the average deductible paid by beneficiaries (see footnote 42); therefore, we would not expect there to be a dramatic shift in costs to beneficiaries.

It is important to note that the impact of a unified deductible on out-of-pocket spending should be examined across a beneficiary’s lifetime. However, in our example, we limited our discussion to the effects on a beneficiary’s spending during a given year. As a result, Beneficiary #3 was deemed “worse off” because he or she would have paid a higher amount under the $250 unified deductible. While he or she would be slightly worse off in that year, he or she would have a much lower level of cost-sharing in the following year if he or she required hospitalization. Similarly, while Beneficiary #1 was deemed “better off” under the $250 unified deductible, he or she would have a higher level of cost-sharing in the following year if he or she used a comparable level of Part B services but was not hospitalized. Therefore, a beneficiary’s situation may vary from year to year.

In general, many of the additional costs might not be borne entirely by beneficiaries, at least not directly. If Congress decided to enact legislation requiring only those Medigap policies currently covering both the Part A and Part B deductibles to cover the new unified deductible—and if employers and Medicaid automatically covered the new deductible—then many beneficiaries with higher Medicare cost-sharing could have these costs paid by their supplemental insurers (beneficiary-paid Medigap, retiree or employer coverage, or Medicaid). There are three standardized Medigap plans currently covering both the Part A and Part B deductibles. Insurers offering these plans might also benefit from any reductions in cost-sharing by those beneficiaries who required hospitalization. The net impact could have an indirect effect on beneficiaries by either raising or lowering their supplemental premiums, depending on the direction and magnitude of the overall change. Moreover, while beneficiaries who formerly received coverage for the Part A, but not Part B, deductible under one of the six standardized
Medigap plans would no longer receive protection against the unified deductible, they might benefit from lower supplemental insurance premiums.

On the other hand, Congress could decide to no longer permit any Medigap plans to cover the deductible in order to control costs. If this occurred, then beneficiaries would be liable for the entire deductible, regardless of their Medigap policy choice, unless they had incomes low enough to qualify for Medicaid coverage. As a result, many beneficiaries could face higher out-of-pocket spending for deductibles (although they might also face lower supplemental insurance premiums).

The analysis in Table 2 implicitly assumes that health care utilization is not affected by the change in the deductible. In reality, however, utilization would be expected to change, although the magnitude of its impact is difficult to predict. The greatest change in utilization is likely to be for Part B services by those beneficiaries who have not already reached their deductible and who do not have supplemental insurance. It is unlikely that inpatient hospitalization decisions are as influenced by the deductible; rather, it is likely they are more dependent on medical need as determined by a physician. However, beneficiaries choosing whether to see a physician are more likely to consider the cost if they have to pay 100 percent of the cost between the current $100 Part B deductible and a $250 unified deductible out-of-pocket rather than if they have to pay only 20 percent coinsurance on that amount. (The effects would likely be negligible for those beneficiaries whose supplemental insurance would pay the extra costs.) It is also possible that the unified deductible might increase HMO enrollment for beneficiaries who expect to use only Part B services, since many HMOs do not charge deductibles.

The impacts on utilization would likely be greater if a unified annual deductible were set substantially higher. For example, suppose that rather than setting the deductible at a typical level used in private insurance, it were set at the sum of the current Part A and Part B deductibles (i.e., $768 hospital deductible + $100 Part B deductible, or $868 in 1999). Such a large deductible would have a stronger dampening impact on utilization Part B services than would the $250 annual deductible, since beneficiaries without supplemental coverage would be paying a greater share of the cost of physician services out-of-pocket. The net effect on utilization of hospital services is difficult to determine. Utilization of hospital services might decrease due to the higher deductible. However, since, other things being equal, utilization of physician services would likely decrease, there might be some substitution toward inpatient care.

Moreover, particularly with such a large deductible, different patients with the same medical condition might incur a substantially different deductible and, therefore, different incentives to obtain (or not to obtain) medical care. For example, suppose that two patients both required physician services that would cost $500. The patient who had

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48 Using data from the Rand Health Insurance Experiment, Manning, et al. (1987) found the demand for inpatient services was less responsive to coinsurance changes than was the demand for physician visits. Inpatient services tend to be less discretionary than outpatient visits.

49 See, for example, Mercer/Foster Higgins (1997).
been hospitalized and had already met the $868 deductible would face a 20 percent coinsurance requirement, or $100 in costs. However, a similar patient who had required no medical care that year would be required to pay the entire $500. This second patient might decide to forego the care, particularly if he or she were a low-income beneficiary without Medicaid assistance. While this might reduce unnecessary physician visits, it could also lead to higher health care costs if, by postponing care, the beneficiary worsened his or her medical condition. While this could also occur with a lower deductible, the deterrent to care is likely to be much more substantial with a higher deductible. Similarly, to the extent that impacts on utilization are negated by the existence of supplemental coverage, the cost of obtaining that coverage might rise correspondingly.\textsuperscript{50}

### Catastrophic Stop-Loss

Currently, unlike most private insurance plans, Medicare has no catastrophic cap on beneficiary out-of-pocket liability. Under such stop-loss protection, a beneficiary would not have to continue paying out-of-pocket for Medicare services once they have reached the maximum. That there is no limit on a beneficiary’s cost-sharing has been viewed by some analysts as one of Medicare’s greatest weaknesses.\textsuperscript{51} As discussed in Section IV, such a feature is consistent with the “optimum” insurance model. If policymakers determined that such a spending limit were desirable, they would have to determine the proper level. A uniform cap would avoid the need to artificially place separate caps on Part A or Part B liability.

### Beneficiary Premiums

Currently, beneficiaries only pay premiums for Part B services, since Part A is largely financed by payroll taxes, interest income, and taxation of a portion of Social Security benefits. Beneficiary premiums account for about 25 percent of Part B costs, or approximately 10.4 percent of total Medicare costs between 1999 and 2007. As a result of BBA’s shift of some Medicare services to Part B—and because premiums are still required to cover 25 percent of Part B costs—this proportion is expected to rise to 12 percent of total Medicare costs by 2007 (CBO, 1998).

If Part A and Part B were combined, the federal government could set a target level of Medicare costs which would be covered by the Medicare premium, similar to what it currently does with Part B. For example, it could require that premiums be set to continue to cover 12 percent of all Medicare costs after 2007. Alternatively, it could decide not to tie premiums to a share of Medicare spending, but to link them to another standard (such as the rate of general inflation, growth in GDP, or the rate of medical care

\textsuperscript{50} The impact of a deductible of this size could give beneficiaries who use only Part B services a much greater incentive to enroll in HMOs than would a lower deductible.

\textsuperscript{51} See, for example, Moon (1996).
inflation). However, tying the growth in beneficiary premiums to one of these targets would eliminate the current link between Medicare program costs and beneficiary premiums, so that the impact on future beneficiaries’ premiums would be uncertain.

VII. Conclusions and Policy Implications

Medicare, widely considered to have been successful in lessening the financial burdens of health care on older Americans, is also viewed as a program in need of a more updated management structure. The two-part system that drives many of its payment and revenue policies would almost certainly not be adopted if the program were being designed today. The current design reflects factors that, while relevant when Medicare was initiated in 1965, are not pertinent today.

Unifying Medicare into a single system could have a number of desirable effects. A unified Medicare system could adopt a more rational cost-sharing structure that both reflects the changing economics of today’s health care system and better achieves the desired effects on utilization of a deductible. Furthermore, a unified Medicare system could give policymakers more flexibility in adjusting to shortfalls in financing, because there would no longer be a distinction between Part A and Part B revenues and outlays. Finally, a unified program could permit Medicare administrators and Congress to more easily adapt the program to an increasingly more integrated health care delivery system.

Combining Part A and Part B of Medicare might also raise a number of potential difficulties. Merging Part A and Part B would almost certainly have an impact on beneficiary out-of-pocket payments, but measuring the impact is difficult, given the range of possibilities such a unified structure could take. These impacts would need to be carefully analyzed to determine how different subgroups of beneficiaries would be affected. The magnitude of the change in out-of-pocket health care payments—as well as the direction for any given beneficiary—would be dependent on the particular way in which deductibles and cost-sharing are changed, and the rules concerning supplemental insurance. Another potentially thorny issue that would have to be resolved involves the definition of solvency within the Medicare program, since the unified system would combine a mandatory self-financed program (Part A) and voluntary subsidized insurance (Part B). Combining Part A and Part B would also require consideration of changes in Congressional oversight responsibility and program administration to reflect the fact that the programs were no longer separate.

If Medicare were to become a unified system, it likely would be part of more wide-scale program changes. Such reforms would raise many additional issues not discussed in this paper. Regardless of the magnitude of changes enacted, creating a unified structure would be consistent with aligning Medicare with changes in health insurance that have occurred since the program’s creation. Indeed, a unified structure

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52 This link exists in that Part B premiums are set equal to roughly 25 percent of Part B costs.
may be necessary to offer Medicare more flexibility to provide access to affordable, high quality care in a continually changing health care environment. Nonetheless, the impacts of combining Part A and Part B would depend on the particular changes involved and on the ways in which the issues discussed in this paper were addressed. Thus, proposals to merge Part A and Part B, as part of broader program changes, would need to be scrutinized carefully to determine how beneficiaries and the program might be affected.
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