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Perspective
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# The Insurance Value of Medicare

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Medicare is an insurance program. The reason we have health insurance at all is not that health care is expensive, but rather that there is great uncertainty about who will need very expensive and potentially lifesaving care and when they will need it. Medicare should give beneficiaries not just access to medical care, but also protection from the risk of catastrophic spending. At the same time, Medicare — like any good insurance — should not cover so much care so generously that beneficiaries end up consuming too much care of questionable value and driving up costs for everyone. Thus, setting cost sharing for Medicare beneficiaries is a balancing act: too little cost sharing means patients have no incentive to spend Medicare dollars wisely; too much means Medicare fails to perform its insurance function.

How well does Medicare do at this balancing act? Not very. Medicare by itself offers only limited protection against economic ruin. The basic benefit lacks a cap on out-of-pocket spending, so beneficiaries are exposed to the risk of open-ended cost sharing that can generate substantial financial strain (or deplete assets for surviving spouses).[1] Moreover, the odds of facing a catastrophic expense mount over time. Almost 50% of beneficiaries are hospitalized at least once over a 4-year period.[2] Without supplemental insurance, 14.5% of beneficiaries would have faced out-of-pocket expenses of more than $2,500 in 2009, and more than half would have had at least 1 year between 2000 and 2009 when their out-of-pocket expenses would have amounted to $2,500 or more (see table). Fifteen percent would have had at least 1 year between 2000 and 2009 when their out-of-pocket expenses exceeded $5,000 — more than a third of the average annual income from Social Security for a retired worker. And these figures are for hospital, outpatient facility, and physician care only; beneficiaries face additional cost-sharing liability for other categories of care, such as prescription drugs, medical equipment, and skilled-nursing facilities.

Beneficiaries without any supplemental coverage thus do not have enough insurance and face too much risk. This risk is one reason that 90% of beneficiaries obtain some other type of insurance (e.g., retiree health benefits, Medigap, Medicare Advantage, or Medicaid).[2] But beneficiaries with generous supplemental coverage probably have too much insur-



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Medicare Beneficiaries' Annual Cost-Sharing Liability for Hospital, Outpatient, and Physician Services.*

| Variable | In 2009 | In Any Single Year between 2007 and 2009 | In Any Single Year between 2005 and 2009 | In Any Single Year between 2000 and 2009 |
|---|---|---|---|---|
| Cost-sharing liability (% of beneficiaries) | | | | |
| >$1,000 | 35.6 | 60.0 | 72.6 | 87.2 |
| >$2,500 | 14.5 | 27.9 | 37.4 | 53.2 |
| >$5,000 | 4.0 | 7.5 | 10.1 | 15.1 |
| >$10,000 | 0.9 | 1.6 | 2.0 | 2.4 |
| Average expenditures ($) | | | | |
| Medicare | 8,587 | 8,288 | 8,226 | 7,857 |
| Beneficiary cost sharing | 1,279 | 1,254 | 1,252 | 1,232 |

* Data are from Medicare claims files for inpatient, outpatient, and carrier (physician) use, expressed in 2009 U.S. dollars. Shown are the proportion of beneficiaries that face cost-sharing liability above the thresholds listed in each row for any single year within each of the designated periods. These figures exclude other categories of care covered by Medicare (e.g., durable medical equipment) for which beneficiaries may also incur cost-sharing liability. Estimates for 2009 from the Medicare Payment Advisory Commission that include the cost-sharing liability from all categories covered by Parts A and B (but not prescription drugs) suggest that 6.0% of beneficiaries would face cost-sharing liability of more than $5,000, for example.[2] These expenses may be paid out of pocket or by a third party (e.g., a Medigap plan).

ance. "Too much insurance" may seem like a nonsensical concept, but there is ample evidence that when copayments are lower, patients consume more care, much of which is of questionable benefit to health.[3] The systemwide effects are considerable: the increasing prevalence of health insurance in the United States is estimated to be responsible for about half the increase in per capita health care spending between 1950 and 1990.[4] Having little or no cost sharing may lead enrollees to consume low-value care and drive up the cost of Medicare for everyone.

Nonpartisan and bipartisan groups such as the Congressional Budget Office, the National Commission on Fiscal Responsibility and Reform (also known as the Bowles–Simpson Commission), and the Medicare Payment Advisory Commission have advanced proposals that would address the imbalance in risk facing beneficiaries in the current Medicare program. Although these groups do not propose exactly the same fixes, some of the basic ideas are the same: First, put a cap on the out-of-pocket spending that beneficiaries are responsible for — as most private plans already do — so that those with no other coverage are protected from catastrophic costs. Second, restrict "first-dollar coverage" (coverage with no cost sharing by beneficiaries) in Medicare supplemental insurance, either by banning it or by imposing a surcharge on plans that provide it. This surcharge would reflect the additional cost to the Medicare program imposed by the extra use of (low-value) care by beneficiaries who face no cost sharing because of the supplemental plan — since the private premiums charged for those plans do not reflect that additional public cost.

These proposals are controversial. The Medicare Catastrophic Coverage Act of 1988, which would have capped beneficiary out-of-pocket spending, proved so controversial that, even though it was passed by Congress, it was repealed before it went into effect. Placing a cap on beneficiary cost sharing would increase program spending at a time when there is intense pressure to cut spending. Restricting first-dollar supplemental coverage would cut program spending but is politically unpopular because it requires lawmakers to tell most beneficiaries that they cannot have the insurance (often private insurance) they are used to having. Furthermore, crude cost sharing that ignores the differences in health benefits produced by different types of care could reduce consumption of highly effective care as much as it reduces consumption of low-value care, especially for low-income populations. Nonetheless, striking a better balance between spreading risk and promoting efficiency would make Medicare a better insurance program.

As a Medicare solvency crisis approaches slowly but inexorably, pressure to restructure the pro-



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gram in order to reduce spending will only increase. Proposed reforms are typically evaluated on the basis of how they affect the bottom line — the exhaustion date of Medicare's hospital insurance trust fund or the share of the gross domestic product devoted to Medicare. They are also evaluated on whether their burden is borne, on average, by providers or by beneficiaries. These metrics are not enough. Reforms must also be evaluated in terms of how they affect beneficiaries' risk of being exposed to high expenditures — and whether they strike a better balance between financial protection and preserving incentives to consume care wisely.

Technological innovation raises the stakes. Many new technologies are crucial for extending life and improving well-being but also create even greater uncertainty about health care spending both for individuals and for the health care system overall. Medicare's balance between financial protection and incentives for efficient use of care would require continual adjustment even if budgetary pressures were not creating an imperative for reform.

Medicare was always intended not just to increase access to care but to protect the elderly from financial ruin. As President Lyndon Johnson said when signing Medicare into law in 1965, "No longer will illness crush and destroy the savings that [older Americans] have so carefully put away over a lifetime so that they might enjoy dignity in their later years." Indeed, the introduction of Medicare reduced out-of-pocket spending among the top quartile of spenders by 40%.[5] Will Medicare continue to fulfill this promise in decades to come? Medicare reforms that strike a balance between financial protection and incentives for efficient use of care will help to ensure that the program will be solvent for future generations without undermining the fundamental insurance value of this public insurance program.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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# Medicare's Enduring Struggle to Define "Reasonable and Necessary" Care

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> No payment may be made . . . for any expenses incurred for items or services, which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
>
> — Sec. 1862(a) of the Social Security Act

The Medicare program, among its many functions, serves as the country's preeminent organization for the assessment of health technology. Its decisions to cover and pay for medical technology can have profound consequences for patients' access to therapies, physicians' treatment options, and the fiscal well-being of the program.

Since its inception in 1965, Medicare policy has been guided by legislation mandating that the program not pay for items and services that are not "reasonable and necessary." Over the years, amid escalating costs and the medical community's embrace of evidence-based medicine, the Centers for Medicare and Medicaid Services (CMS) has struggled to interpret and apply the "reasonable and necessary" criteria. At key junctures, CMS has been thwarted by political pressure or the courts. As Medicare spending takes center stage in the country's budget debates, "reasonable and necessary" warrants a closer look.

Defining "reasonable and necessary" has proven an enduring challenge. Determinations of what



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