BRIEF ANALYSIS
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What's At Stake for the Elderly in Health Care Reform?

The American Association of Retired Persons (AARP) has endorsed the two latest versions of the Clinton health care plan: bills by Senator George Mitchell (D-ME) and Representative Richard Gephardt (D-MO). In doing so, AARP has betrayed its members. Even though both bills promise new benefits for the elderly, including prescription drugs and home health care, they do nothing to pay for the benefits. In fact, both bills would cut Medicare funding by billions of dollars.

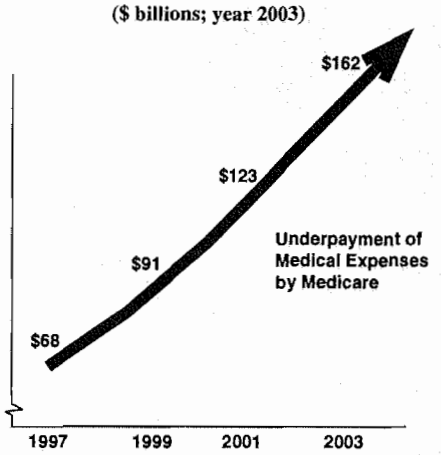
The consequence would be an ever-widening gap between the cost of promised benefits and the amount Medicare is willing to pay:

- Under the Mitchell bill, underpayment of medical expenses by Medicare would more than triple — growing from $44 billion this year to $162 billion by the year 2003. [See Figure I.]
- As a result, Medicare reimbursements to hospitals, doctors and other providers in 2003 would be only 70 percent of the actual cost of treating Medicare patients. [See Figure II.]
- Thus almost one out of every three health services for the elderly would have to be either rationed or paid for by shifting the costs to other patients.

FIGURE I

Clinton/Mitchell Bill

($ billions; year 2003)



Note: The figure shows the amount by which Medicare reimbursements to hospitals, doctors and other providers will fall short of the actual cost of treating Medicare patients. Either these costs must be shifted to other patients or the elderly will receive reduced quality care or rationed care.

Source: Calculations by Gary Robbins and Aldona Robbins, using the National Center for Policy Analysis/Fiscal Associates Health Care Model. (These estimates are static and do not take into account the behavioral ehanges that would result from changed incentives.)

Cost Shifting. "Cost shifting" occurs when one group of patients pays less than the true cost of their medical care. In order to stay solvent, providers must cover these losses by overcharging everyone else. No one knows precisely how much cost shifting there is, and its magnitude is open to debate.

Based on Congressional Budget Office (CBO) assumptions, we estimate that uninsured patients will cause about $26 billion in costs to be shifted to paying patients this year. A more important source of cost shifting is that Medicare and Medicaid routinely pay less than the real cost of the services their beneficiaries receive. Hospitals and doctors must either accept the reduced rates or be excluded from the programs. We estimate that cost shifting in 1994 will be $44 billion from Medicare and $34 billion from Medicaid. Combined, Medicare and Medicaid cause about three-fourths of all the cost shifting in the health care system today.

Medicare's Bleak Future. The best-kept secret in the current health care debate is that Medicare is already in trouble. Because the Medicare payment gap is growing, Medicare recipients will have increasing difficulty obtaining the benefits they supposedly are entitled to. Even with no change in the current health care system:

- Based on CBO assumptions, we estimate that the amount by which Medicare reimbursement falls short of actual costs will grow to $108 billion by 2003.
- Over the next ten years, about one out of every five health care services for the elderly will have to be rationed or paid for by shifting costs to other patients.

Why Cost Shifting May Become Impossible. Not all health economists agree with the CBO. In a study produced for the American Enterprise Institute, Professor Michael Morrisey argues that there is very little cost shifting. When the government underpays for Medicare and Medicaid services, Morrisey says, the patients tend to receive lower-quality (less costly) care.

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Morrisey's argument is more persuasive with respect to Medicaid patients (who are restricted to the few doctors willing to treat them and the few hospitals willing to admit them) than to Medicare patients (who have many more options). However, in the future even Medicare patients may find it impossible to get part of their costs shifted to other patients.

The reason is that the medical marketplace is increasingly competitive. In competitive markets, cost shifting is impossible because prices reflect the true cost of services and providers are unable to charge one person more than another.

Medicare vs. Medicaid. Under the current system, Medicaid underpays even more than Medicare. But both Democratic versions of Clinton health reform would greatly expand options for the poor even as they create pressures to ration care for the elderly. For example:

- Under the Mitchell bill, Medicaid patients would join private health plans and have their premiums paid by the government.
- Since private insurers reimburse providers at much higher rates than does the Medicaid program, Medicaid beneficiaries would have the same options as private patients.
- Thus Medicaid patients would have far more options and get better medical care than the elderly.

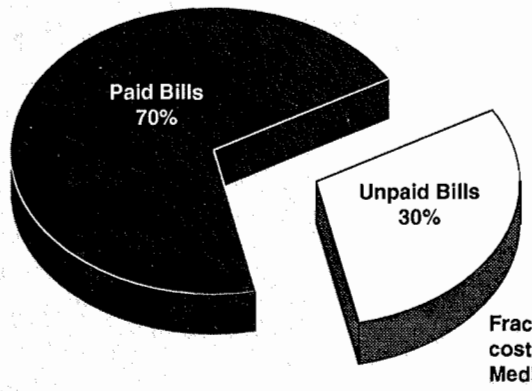
Under the Gephardt bill, Medicaid recipients would be put into a new Medicare Part C program, which presumably would reimburse providers at the same rate as the Medicare program for the elderly (Parts A and B). But since the bill also allows millions of other Americans to enroll in Medicare Part C, the program eventually would cover about half the U.S. population.

Under Gephardt's bill, the Medicare underpayment gap would become so huge that the cost shifting required would be impossible. A two-tier system of health care would likely emerge, under which the best doctors would simply refuse to see Medicare patients and the best hospitals would refuse to admit them.

FIGURE II

Clinton/Mitchell Bill

(year 2003)



Source: Same as Figure I.

Medicare Rationing: It's Already Here. We don't have to speculate about the future in order to understand the effects of persistent underpayment. Medicare's payment policies already cause rationing, especially for procedures requiring advanced technology. Academic studies of this issue have brought to light the following:

- Hearing loss is the most prevalent chronic disability in the United States, affecting 30 percent of people over the age of 65; yet researchers found Medicare's reimbursement rate so low that most patients who need a cochlear implant cannot get one.
- Another study found that Medicare's payment for kidney dialysis fell 44 percent in real terms between 1983 and 1990, and the physician's payment was frozen over the same period; in response, dialysis centers reduced their levels of treatment to the apparent detriment of patients.
- A Rand Corporation study found that in response to a change in the way Medicare pays hospitals, patients are admitted "sicker" and released "quicker and sicker" and more are released in unstable condition, which makes them one and one-half times more likely to die within 90 days.
- Other researchers found that elderly patients with hip fractures are released in poor condition to nursing homes — a practice which deters their long-term recovery.

Note: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any legislation.