National Center for Policy Analysis

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Medical Savings Accounts For Medicare

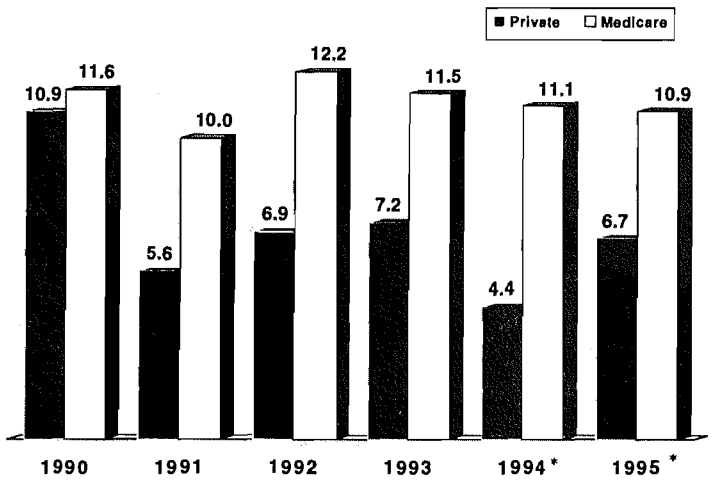
The Republican Congress has promised to balance the budget by the year 2002 — with or without a balanced budget constitutional amendment. According to most budget analysts, that means cutting the growth of Medicare — some say by half.

Yet Medicare already is beset by problems that many attribute to too little spending. Because Medicare underpays doctors, many refuse to take new Medicare patients. Because Medicare underpays hospitals, some prematurely discharge patients and deny Medicare beneficiaries access to technologies available to other patients.

Is there a way to simultaneously cut the spending and solve the problems of the Medicare program? Many health policy analysts believe the answer is Medical Savings Accounts.

FIGURE I

Health Care Spending
(Average annual percent change)



* Projected

Source: Health Care Financing Administration, Office of the Actuary.

Problem: Rising Costs. Medicare is probably the only large health insurance plan in the country that has not undergone fundamental change over the past decade. Many employers have increased deductibles and copayments — requiring employees to manage more of their own health care dollars. More frequently, employers have begun directing their employees to lower-cost doctors and actively managing health care costs.

Medicare has moved in the opposite direction. In recent years, deductibles for Part A (hospital insurance) have not changed in real terms, and the deductible for Part B (other medical expenses) has actually decreased in real terms. While there have been some managed care demonstration projects with the Medicare population, in most places Medicare is still a wide open, fee-for-service plan in which patients can see almost any doctor for any service.

These features may explain why Medicare has done such a poor job of controlling costs. As Figure I shows, in recent years private sector health care costs have grown much more slowly than those of Medicare.

Problem: Price Fixing. In its effort to contain spiraling Medicare costs, the federal government has resorted to price fixing rather than negotiating and competitive contracting. Bureaucrats determine how much doctors and hospitals get paid for delivering services to Medicare patients. According to the Congressional Budget Office, Medicare pays doctors and hospitals, on the average, about 70 percent of the costs of the services they provide the elderly. Where they can, providers shift costs by overcharging private patients. However, in an increasingly competitive market, this is less and less possible. Thus, Medicare's underpayment is resulting in reduced access and lower-quality care for some elderly patients.

Problem: Rationing and Lower-Quality Care. Other Medicare practices exacerbate the impact of underpaying for services. For example, Medicare pays the same fee, regardless of the quality of care provided. This encourages lower-quality, less-expensive care. The system also allows hospitals to make more net income by discharging patients earlier, regardless of health condition, and evidence suggests that premature discharges have harmed some patients. Medicare is also slow to

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approve new medical technologies, leaving the elderly without access to the latest and best treatments and care.

For example, cochlear implants are far superior to previous technology for treating some types of hearing loss. But the elderly under Medicare are stuck with hearing aids because Medicare doesn't pay for the more costly implants.

Solution: Private Health Insurance. Current law already allows some Medicare beneficiaries to withdraw from Medicare and join an HMO instead. While no one should be forced to leave Medicare, we should build on this precedent and allow each Medicare beneficiary to have two private insurance options: a private catastrophic plan coupled with a Medical Savings Account or membership in an HMO.

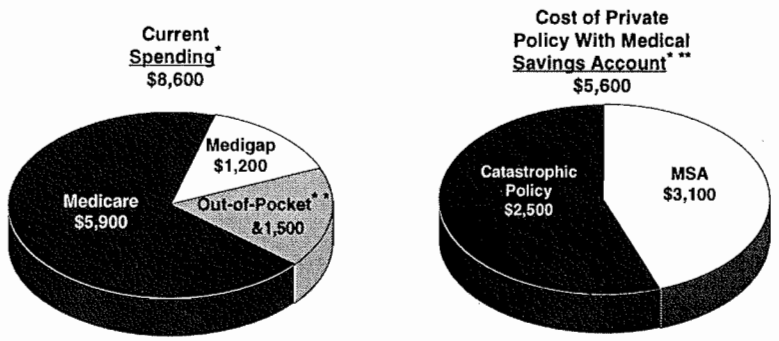
The private health plan should cover services now covered by Medicare and receive 95 percent of the actuarial value of Medicare spending. People could add the funds they currently use to pay supplemental Medicare (Medigap) premiums and out-of-pocket medical expenses. The additional premiums plus cost savings could finance such extra benefits as long-term home health care, complete catastrophic coverage and prescription drugs.

Solution: Medical Savings Accounts. Under the Medicare MSA option, individuals would obtain catastrophic insurance to cover all expenses over a high deductible (say, $2,000 to $3,000) and a Medical Savings Account to pay expenses below the deductible. Unspent MSA funds could be withdrawn at year-end for any purpose, saved for future medical expenses or used for long-term care benefits. Investment returns on the MSA funds would be tax free.

FIGURE II

Costs per Medicare Beneficiary

(Hypothetical Example)



* Source: "Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans," prepared by the Public Policy Institute, American Association of Retired Persons and the Urban Institute, April 19, 1994.

** Direct out-of-pocket expenses, not including Medicare Part B premiums, Medigap premiums or payments for long-term care.

*** Assumes $3,000 deductible.

A Numerical Example. Here's how such an option would work if the program began in 1996: Average per capita Medicare spending next year will be about $5,900 (including both Parts A and B). Each recipient would be able to apply 95 percent of that to a private plan — for a total of $5,605.

Based on a preliminary analysis by actuaries, the National Center for Policy Analysis estimates that if MSAs are offered as an option and half the beneficiaries choose one, the $5,605 premium would provide private catastrophic coverage (with a $3,000 deductible) and more than $3,000 for an MSA. [See Figure II.] As a result, the elderly would have no out-of-pocket exposure.

Were the entire Medicare population to opt for an MSA plan, the catastrophic premium would be about $3,500, leaving about $2,100 to be placed in an MSA. Beneficiaries would pay the first $2,100 of medical expenses from their MSA and the next $900 out of pocket. Insurance would pay any remaining bills. Beneficiaries could top up their MSA and avoid any out-of-pocket exposure for less than they now spend on Medigap insurance. [See Figure II.]

Benefits of Reform. Since people would effectively be spending their own funds out of the MSAs, they would have excellent incentives to eliminate waste and inefficiency and to control costs. They could use their MSA funds to buy whatever services they prefer from any doctor or hospital they choose. And they could afford to expand coverage to include other services.

This Brief Analysis was prepared by NCPA Senior Fellow Peter J. Ferrara and NCPA President John C. Goodman.