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Solving the Medicare Crisis

Federal budget experts across the political spectrum agree that the Medicare program is having a financial crisis. This one program already accounts for 11 percent of the entire federal budget, and is exploding at the unsustainable pace of 10 percent per year. Congressional leaders are aiming to reduce the growth in the program to 5 percent per year.

Without fundamental change, the future looks bleak. Medicare will go bankrupt by 2002. In 2005, just 10 years from now, Medicare alone will be adding about $100 billion a year to the federal deficit in today's constant 1995 dollars. By 2010, Medicare alone will be increasing the deficit by almost $200 billion a year in today's dollars, almost as much as the entire federal deficit today. Under the government's own projections, by the time today's young workers retire, paying all promised benefits will require increasing the current Medicare payroll tax rate of 2.9 percent anywhere from three to six times, depending on the assumptions. Without fundamental reform, Medicare premiums paid by the elderly also will have to rise by three to seven times relative to their income, or $4,000 to $8,000 per couple in today's terms.

Steps to Medicare Reform

- Create private insurance alternatives
- Pay risk-rated premiums to private plans
- Allow Medical Savings Accounts
- Cap Medicare growth

Fortunately, there is a better way. The necessary budget savings can be achieved while providing substantial benefits to the elderly by giving them greater control over Medicare funds, and their own health care.

Private Insurance Options. The essence of the reform proposals shown in the sidebar is to allow the elderly to withdraw from Medicare Parts A and B and choose an alternative, private plan, including a Medical Savings Account (MSA), a health maintenance organization (HMO) or an employer's health plan. Each retiree would be free to remain in Medicare and not choose any private coverage. Therefore, this proposal creates new options without eliminating existing ones.

Risk-rated premiums. The premium payment made by Medicare to the private plan for each beneficiary would be risk-adjusted to reflect the beneficiary's age, sex, geographic and health status. Consequently, those who are older and sicker would receive more from Medicare to purchase private coverage. Those who are younger and healthier would receive less. This would prevent adverse selection raising Medicare costs, since retirees who leave would only take the share of funds that actuarially reflect their own risks.

Private health plans also could negotiate with Medicare for a fee to provide coverage for Medicare patients with special health problems. For example, Medicare might agree to pay a certain fee to a private plan for coverage for each elderly heart patient or cancer patient in a certain area (similar to the centers of excellence program already under way).

Rules for Private Plans. To participate, the private health plans would have to cover the same services as Medicare, though they could offer additional benefits and charge additional premiums. For example, they could offer coverage for prescription drugs, dental care and even long-term care.

The private insurers also would have to accept anyone from Medicare who applied, regardless of health status, along with their risk-adjusted premium. Yet, private health plans would not be required to accept patients switching from other private plans, since that would create perverse incentives for plans to dump their sickest patients on their competitors.

Medical Savings Accounts. One private option would be a catastrophic policy coupled with a Medical Savings Account. For example, private insurance might cover all health expenses over a $3,000 deductible, and place any premium savings in an MSA. MSA funds would then be used to pay for expenses below $3,000. In case a gap remained between the MSA deposit and the catastrophic deductible, the retirees could top up their MSA by contributing amounts they otherwise would have used to purchase private, Medigap insurance or pay out-of-pocket expenses.

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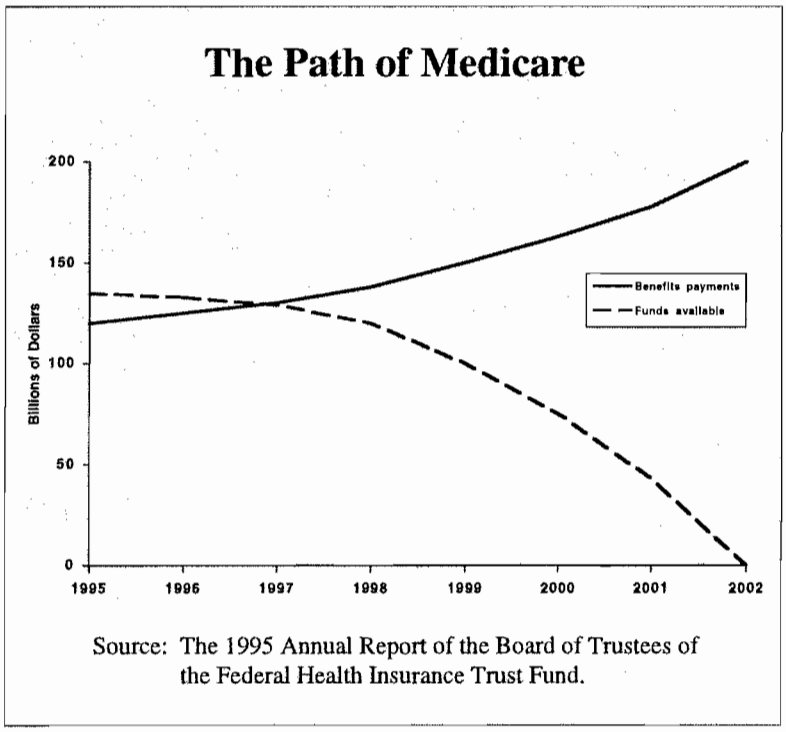
There would be no tax deductions for funds contributed to the MSA. But returns on MSA investments, as well as all withdrawals for any purpose, would be tax free. During a 12-month insurance period, MSA funds could only be used for medical expenses, since the purpose of the MSA is to back up a high deductible. However, retirees could withdraw any remaining MSA funds at the end of each year.

Capping the Growth of Medicare. The final component of the reform would be to insure that Medicare spending does not grow faster than a target rate. The growth rate could be capped at 5 percent, meeting current budget goals. Or, it could be set equal to the rate of growth of private sector spending on the theory that working taxpayers should not have to bear the burden of Medicare taxes growing at a faster rate than their own private health insurance.

This goal could be accomplished by increasing deductibles in whatever amount is needed to hold total program costs to a target growth rate. This would reduce Medicare expenditures for the smaller, routine expenses, while maintaining essential coverage for higher expenses. The low-income elderly would be exempted from these increases, and the others could purchase private coverage to meet the deductibles, as most do today.

Medicare spending also could be curtailed by increasing Medicare co-payment fees, particularly for home health care and other benefits where no co-payment currently applies. The Medicare retirement age could be increased by one month per year (although this hurts minorities with shorter life expectancies). Cutting Medicare payments to hospitals and doctors is popular in Congress (but since Medicare already seriously underpays for services, this might threaten the quality of care for the elderly).

Increasing the deductible for Medicare is a far preferable means of cutting the program's costs than increasing Medicare premiums. Those premiums are already a heavy burden, costing about $1,100 per year per elderly couple. Raising them further would resurrect the same opposition that killed the Medicare catastrophic health legislation in the late 1980s. Increasing the deductible is politically more appealing because it leaves the funds in the hands of the elderly. By contrast, increasing the premiums gives the government more money to spend.



Source: The 1995 Annual Report of the Board of Trustees of the Federal Health Insurance Trust Fund.

Benefits of the Reform. Under these reforms, the necessary budget savings would be assured, and this would substantially alleviate the long term Medicare financing crisis. The Medical Savings Account option would provide powerful incentives to elderly patients to control costs, reducing Medicare expenditures even further. Moreover, the elderly would receive substantial additional funds each year to supplement their retirement income, by conserving on health costs and withdrawing remaining MSA funds at the end of each year.

The MSA option would allow the elderly the freedom to choose the benefits they want, provided by the doctors and hospitals they want. It also would provide full catastrophic coverage, which Medicare beneficiaries do not currently have, since private insurance would cover all expenses over a high deductible.

These proposals consequently achieve budget savings in the context of fundamental reforms that would be highly beneficial and appealing to the elderly.

This Brief Analysis was prepared by NCPA Senior Fellow Peter Ferrara.