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MEDICARE: CRISIS AND OPPORTUNITY

Medicare faces two crises. First, Medicare Part A, Hospital Insurance (HI) will run short of spending authority in 2002, when its trust fund dries up. Second, even if HI were patched up, Medicare does not serve the public well. If continued in its present form, Medicare will become ruinously expensive for workers and retirees. It will continue to drive up health care costs. It will force higher payroll taxes, impeding people's ability to save for their retirement needs, including long term health care for chronic illness or age related frailties not covered by Medicare.

It is impossible to deal with the federal budget deficit without dealing with Medicare. Can reform of Medicare ... be turned to everyone's benefit, eventually providing better care and better protection at lower cost? Yes.

Medicare cannot continue without Congressional action. HI is already running deficits, and is only being kept current in its payments to hospitals by general revenues from the Treasury "redeeming" the trust fund. When the fund vanishes, payroll tax receipts increasingly will lag behind accumulating bills. HI will have to delay payments to providers for longer and longer periods, incurring ruinous, escalating interest penalties, and cash-strapped providers will begin refusing service to the elderly. Something must be done just to keep the program afloat.

It is impossible to deal with the federal budget deficit without dealing with HI and Medicare Part B (Supplemental Medical Insurance (SMI), covering physicians' charges and outpatient treatment). The projected deficits (outlays less tax and premium income) in HI and SMI account for $158 billion, or 70%, of the total federal budget deficit of $227 billion in FY2002.

Outlays for HI will exceed payroll tax revenues and other non-interest income by $6 billion in FY1995, rising to $44 billion by FY2002, a $35 billion jump.

Only about 30% of SMI outlays are currently covered by premiums paid by the program's enrollees. The remaining 70% of SMI outlays are paid for by taxpayers as a direct subsidy from the Treasury. Premiums will fall to 25% of outlays under current law next year, and to 19% by 2002, with taxpayers making up the difference. The taxpayer subsidy is set to explode, from $47 billion in FY1995 to $114 billion in FY2002, a $67 billion jump.

Furthermore, these FY2002 Medicare deficits are only the beginning. The combined Medicare deficits are projected to reach $400 billion a year by 2010, and $1 trillion a year by 2020 as the baby boom generation begins to retire.

The House and Senate Budget Committees' 1996 Budget Resolutions each call for significant deceleration of Medicare's outlay growth. These proposals have been severely criticized as "balancing the budget by slashing medical care for the elderly". Medicare is not being sacrificed to eliminate a budget deficit originating in other areas. These programs ARE the budget deficit. The Bipartisan Commission on Deficit and Entitlement Reform made this point loud and clear. The only

way to keep these programs untouched while balancing the total budget would be to force the rest of the budget into substantial surplus to feed the health care programs. Simply bringing these two programs back into balance through FY2002, or even just preventing their deficits from increasing, cannot reasonably be criticized.

In fact, Senator Domenici's Chairman's Mark trims only $62 billion from the growth of these programs in FY2002, presumably balancing part A (at a level of outlays $70 billion higher than in 1995) and apparently letting the Part B subsidy increase by nearly $50 billion. Representative Kasich's Chairman's Mark trims only $71 billion in FY2002.

Will trimming Medicare growth hurt? In a narrow sense, yes. At least some people who now have nearly a blank check for medical services will face higher deductibles and copayments. The growth of subsidies will be slowed. These cutbacks are preferable, however, to the alternative of a substantial payroll tax rate increase and resulting unemployment.

Is there an up side to all of this? Can reform of Medicare be designed to minimize the hurt, and even be turned to everyone's benefit, eventually providing better care and better protection at lower cost? Yes.

An appropriate reform must start with a review of the goals of the Medicare program. The real need is for a program that assists the elderly with catastrophic expenses, not the expenses for routine care and first dollar outlays (except, perhaps, for the very poor). First dollar health care coverage paid for by third parties (common among the elderly who have social security and medigap policies, and among workers with tax-favored employer-provided insurance) has driven up health care demand by young and old, boosting health care prices, forcing premium and tax increases that damage employment, and wrecking federal and state budgets. A different kind of health insurance is needed.

As one alternative, Medicare already allows enrollees to join HMOs and other managed care plans in lieu of traditional Medicare fee for service payments. Medicare pays the providers a fixed fee of 95% of average Medicare payments for the enrollee's age, gender, and area. Enrollees save money by not having to buy medigap policies, because HMO membership usually includes medigap-covered services.

The limited buyout option has drawbacks. Health savings realized by the patient and provider beyond 5% may not be shared between them as higher profits or a cash rebate, but must be spent on additional medical coverage, such as prescription drugs or lower copayments. Savings are less than 5% of outlays, since only a fraction of the covered population elects this option, and the sickest elderly tend to remain on Medicare. Finally, even if outlay savings of 5% were achieved, it will take far more than that to offset the burgeoning deficits facing the program.

A more promising option involves medical saving accounts (MSAs). MSAs have the potential to rein in rising costs by making health care consumers more cost conscious. Private firms have had considerable success in holding down premiums by providing workers with a medical savings account option.

The MSA concept could be extended to Medicare, as many researchers and Members of Congress have proposed. Medicare would issue an age and gender adjusted voucher to its enrollees at, say, 95% of the current annual outlay per Medicare enrollee (nearly $5000). The vouchers would be enough to buy a catastrophic health care policy with some amount left over to be placed in a Medical Savings Account to cover deductibles and copayments. Enrollees might be allowed to deposit additional money in the MSA. Although the deductibles in a catastrophic policy are higher than under Medicare, on the order of $2,000 or $3,000, such plans can cover more of the cost of extended illness than Medicare. Most enrollees would exceed the deductibles only occasionally, and unused MSA

balances could accumulate quickly to cover the deductibles in those years when they might be exceeded. Enrollees would have an incentive to control their premiums and use of care, because they would be able to keep the savings.

The Medicare enrollee MSA option, while a good first step, would not by itself cut federal outlays on Medicare enough to balance the programs over time. The vouchers would have to grow more slowly than the projected growth of outlays per enrollee under current law. For that to be possible while assuring the elderly of enough resources for health care, Medical Savings Account proposals need to go further. MSAs should also be available to younger people. Annual contributions by employers, employees, the self employed, and other individuals should be permitted, with unspent balances allowed to roll over and compound tax deferred for payment for medical care and other retirement needs.

The attraction to young people of saving in a tax favored manner for retirement by conserving funds in one's MSA would further reduce current health care spending and price pressures on medical care. MSAs would foster national saving, growth, productivity gains, and wage increases. Finally, rising MSA balances would allow federal payments to be reduced over time, at least for those able to pay (that is, except for the very poor). That is a critical feature of any reform that hopes to deal with the deficits projected beyond 2002.

It will not be easy to pass a broad Medical Saving Account option. The paternalistic attitude of many in government that individuals cannot look out for themselves, pressure from HMOs to limit Medicare alternatives to their industry only, and the Joint Tax Committee's biased scoring methods that stack the deck against savings incentives must all be overcome. Overcome them we must, however, if the nation is to have the best health care at a price we can all afford.

Stephen J. Entin
Resident Scholar